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ABSTRACT

Migrant health activities carried on by 17 of the 18 Florida county health departments that are recipients of Federal grants for this purpose from the United States Public Health Service are detailed in this report. Data concerning the number of people treated, descriptions of the medical services available, and a narrative report are included for each project. The county projects described are those for Collier, Broward, Dade, Glades, Hendry, Highlands, Lee, Manatee, Martin, Orange, Palm Beach, Polk, Putnam, Flagler, Saint Lucie, Sarasota, and Seminole counties. Additional topics discussed include Florida's migrant project history, the migrant situation, the Migrant Service Referral System, project objectives for 1968, nutrition services to the migrant health project, the Florida migrant syphilis casefinding project, the migrant dental health program, the health education program, and future plans--the replacement of outmoded slides, the improvement of migrant housing, and the revision of the Health Service Indexes for the 11 participating states. It is concluded that there was, with few exceptions, a definite increase in the amount and variety of services rendered, the number of agricultural migrants brought into contact with these services, and the various activities carried on by migrant project personnel in Florida. A related document is ED 013 699. (HBC)

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Florida

Migrant Health Project

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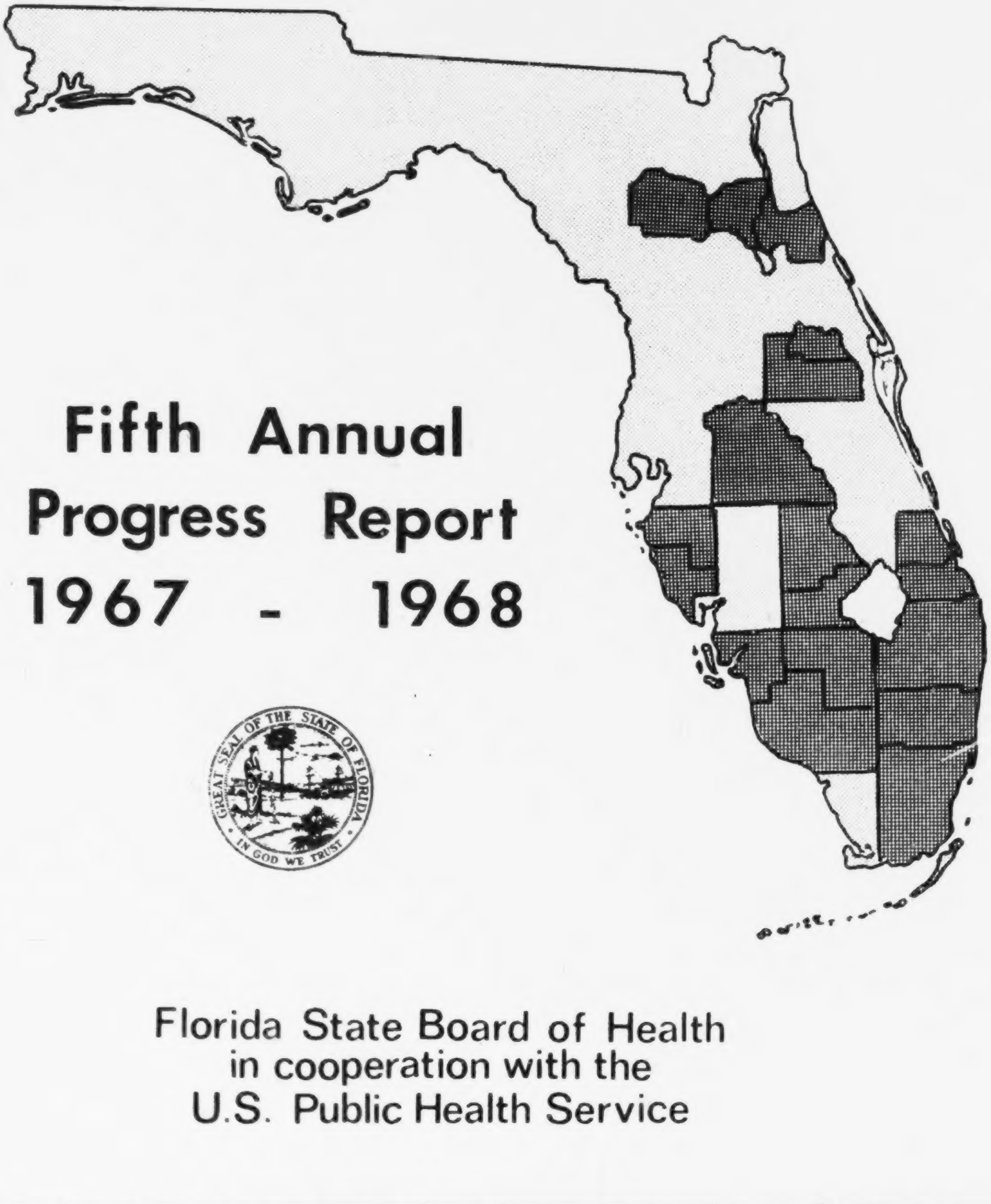

Fifth Annual Progress Report 1967 - 1968

Florida State Board of Health
in cooperation with the
U.S. Public Health Service

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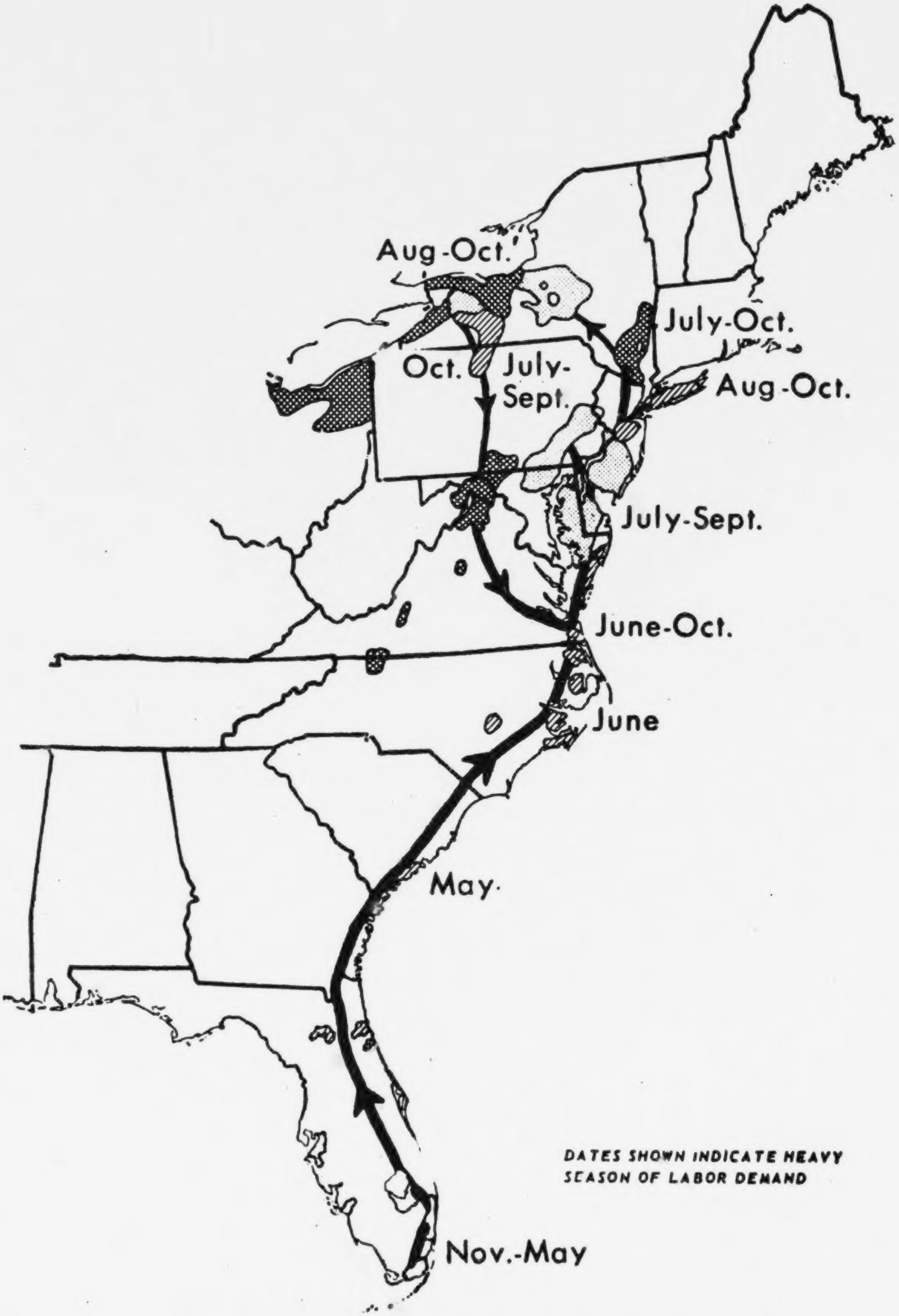
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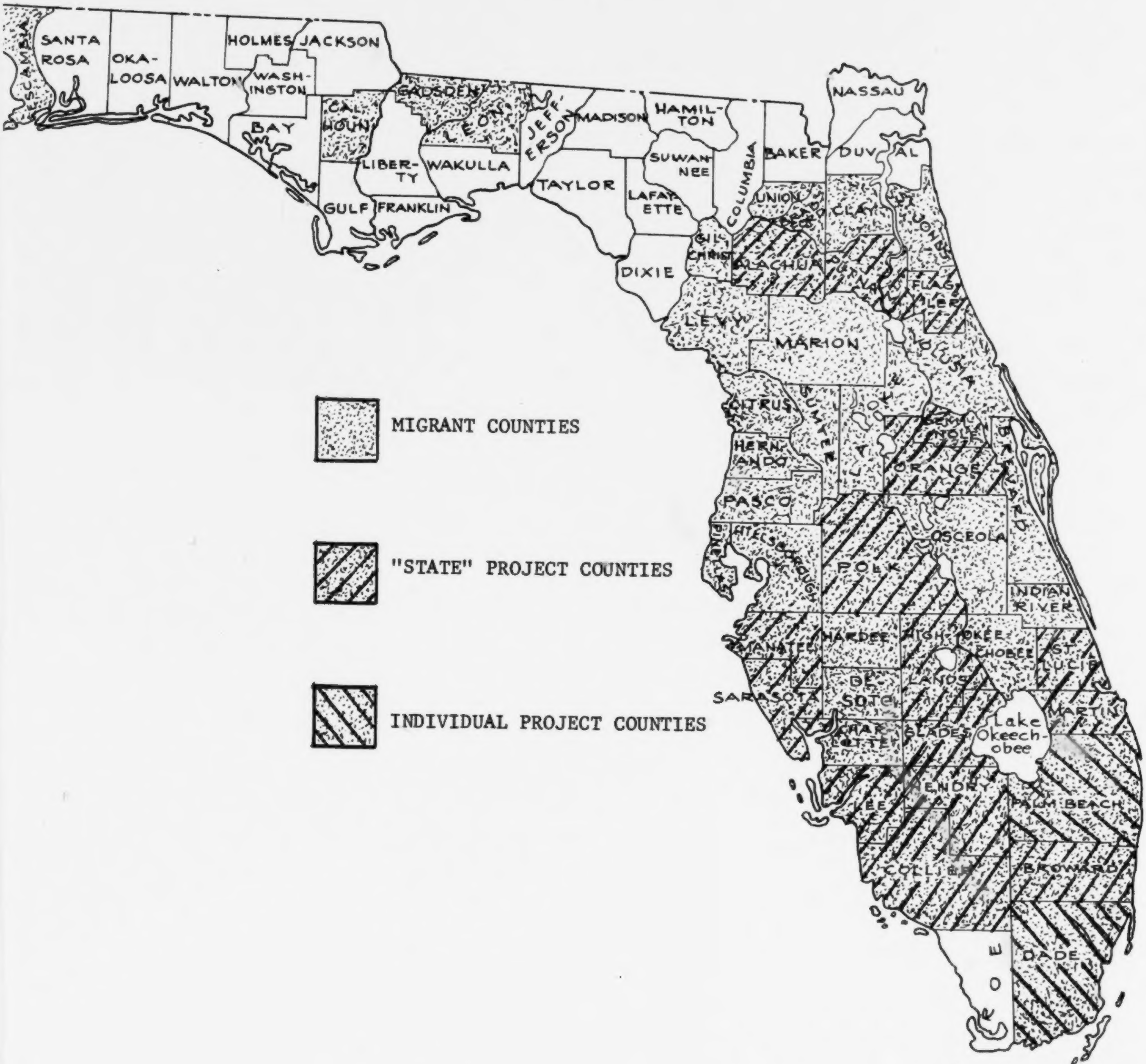
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MIGRANT COUNTIES
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FLORIDA STATE BOARD OF HEALTH

ANNUAL PROGRESS REPORT

MIGRANT HEALTH GRANT MG-18E (68)

PREFACE

This is the Fifth Annual Progress Report on the Migrant Health Program in Florida, to be submitted to the United States Public Health Service.

Migrant health activities carried on by seventeen (17) of the eighteen (18) Florida county health departments who are recipients of Federal grants for this purpose from the United States Public Health Service are detailed in the following pages. In the main, the period covered by the individual reports of these counties extends from May 1, 1967, through April 30, 1968.

For purposes of clarification, it might be appropriate to mention that in previous years the annual project reports published by the Florida State Board of Health were limited to the inclusion of migrant health services provided by those county health departments participating in the Florida "State" Migrant Health Project. The term "State" was employed to differentiate between the multiple-county project and the two (2) separate projects of Dade and Palm Beach counties. These two (2) counties are funded by the United States Public Health Service on an individual basis and the administration of their projects is vested in their respective county health officials. This current annual report comprises the reports of fifteen (15) of the sixteen (16) counties of the "State" or multiple-county project, plus those of Dade and Palm Beach counties. The word "project", when used in subsequent pages of this report (with the exception of the individual county report sections), refers exclusively to the "State" project.

The "State" project is administered by the Bureau of Maternal and Child Health of the Florida State Board of Health. The Bureau Director is E. Henry King, M.D.; the Assistant to the Project Director is William J. Clarke, Jr. The Dade County project is under the directorship of Hunter B. Rogers, M.D. and the Palm Beach County project is under the directorship of Carl Brumback, M.D., Director of the Palm Beach County Health Department.

ANNUAL PROGRESS REPORT

MIGRANT PROJECT HISTORY

The Florida State Board of Health initially received a grant award from the United States Public Health Service in 1963 to inaugurate a migrant project entitled: "A Project to Develop a Basic Statewide Program of Health Services for Migrant Farm Workers and their Dependents in Florida." This title was retained for the second and third years' operation of the project. The title was slightly modified for the fourth year's operation by dropping the word "basic" as it was felt that the project had progressed in many ways by then past the fundamental point and was reaching for the attainment of a more complete status. The first year's operation might be considered as a "planning" year during which information necessary to implement the following year's "action" program was gathered. The project period for the first year extended from September 1, 1963, through August 31, 1964. The First Annual Report covered this twelve (12) month period.

The United States Public Health Service approved Florida's Project Continuation Request and the second or "action" year of the project started in September of 1964. Ten (10) counties comprised the nucleus of the "State" project during the first few months of the second year's operation, but a subsequent Project Revision made it possible for three (3) additional counties to participate and to extend the project period through the calendar year 1965.

Florida's second Project Continuation Request was tentatively approved (subject to some budget revisions) by the United States Public Health Service in the late fall of 1965. The necessary Budget Revisions were later submitted and approved in January of 1966, with the project year designated as February 1, 1966, through December 31, 1966. During this period an additional county joined the project, thereby increasing the total number of counties participating to fourteen (14).

An Application for a Project Renewal to take effect on January 1, 1967, was submitted by the Florida State Board of Health during the summer of 1966 and a subsequent Budget Revision was submitted in the fall. The 1966 grant period was extended by the United States Public Health Service through February, 1967, with the 1967 grant period to be in effect from March 1, 1967, through December 31, 1967. This action, extending the grant period through two additional months, necessitated the submission of an additional Budget Revision, to assure funds for this two month period.

Two additional counties joined the project in March of 1967, bringing the total number of participating counties up to sixteen (16).

During the summer a Continuation Application was submitted for review and was subsequently revised in early December. At the conclusion of the grant year, one of the ten original counties dropped out of the project, thus reducing the number of participants to fifteen. In early January (1968) a grant was awarded by the U. S. Public Health Service continuing the project through the calendar year 1968.

ANNUAL REPORT

FLORIDA STATE MIGRANT HEALTH PROJECT

Migrant Situation

During the 1967-68 agricultural season, migrant workers began arriving during the latter part of August, 1967. On August 31, 1967, there was an estimated seasonal employment of 24,919, of which 23,373 were local; 436 were foreign, and 1,110 were from other areas or other states. About 36 per cent of the employment was concentrated in citrus preharvest and harvest. The small number of foreign workers reported at that time were located in Lake Okeechobee area and were used to cut sugarcane for replanting.

By November 15, seasonal agricultural employment had increased to 52,987 workers. Central Florida citrus harvest for fresh pack, South Florida vegetable harvest and sugarcane harvest for mill operations were all underway. Around 10,445 workers from other Florida areas and other states were now employed in seasonal agricultural activities. About 6,600 foreign workers were engaged in sugarcane operations in the Lake Okeechobee area.

Employment reached peak level on January 31, 1968, with an estimated 78,037 workers. At this time there were approximately 30,700 workers in citrus harvest and grove care, and 9,600 in sugarcane. About 8,400 of the sugarcane workers were from the British West Indies. The ethnic composition of the domestic work force was estimated to be: Anglo, 17 per cent; Texas-Mexican, 15 per cent; Negro, 58 per cent; Puerto Rican, 10 per cent. The Anglo group of workers increased during the past year due to integrated housing being available in all areas and due to the lack of Negro workers. Other opportunities and programs which were developed last year competed for the use of Negro agricultural seasonal workers.

Generally, during the 1967-68 growing season, the labor supply and demand were in good balance. Volume of the 1967-68 citrus crop was considerably below last season's. Harvest began at a normal time, but the volume remained low due to late maturity of part of the crop. Migrant workers began to arrive in sufficient numbers to harvest the crops, and less vigorous recruitment was necessary than for the previous year. The drought which occurred in the spring was unfortunate in many of its effects. It did, however, serve to keep many migrant workers employed in the extensive irrigation work which was needed. Many workers did leave the area before the Valencia crop matured, but an adequate supply of workers is expected to be available for the remainder of the season.

Mechanization continued to increase during the 1967-68 season. In south Florida the harvest of potatoes, radishes and southern peas was accomplished almost entirely by machinery. More growers began using the mechanical harvesters for celery, sweet corn, tung nuts, and tobacco. Little labor was displaced, since more jobs were created by the use of machinery.

Little change in acreage occurred during the past season in vegetables and sugarcane. Some growers switched from high labor-using crops, such as tomatoes, to crops which could be harvested by machinery. Increased citrus acreage will result in an increase in the need for grove care workers and eventually for harvest workers.

Wages were still on the uptrend. Hourly rates increased due to the agricultural wage and hour law which recently went into effect, and some piece rates were also raised. Higher piece rates for citrus were generally due to the scattered crop.

Labor requirements for the 1968-69 growing season are not expected to vary substantially from those of the 1967-68 season. The long drought in the spring may have reduced the anticipated citrus yield somewhat. Employment opportunities in other crops should be generally the same as last year's.

Migrant workers begin leaving Florida during May with heavy migration during June after school terms have been completed. Around 40,000 to 45,000 workers and their families are expected to leave Florida this year. First destinations for most migrants after leaving Florida are in the east coast sections of South Carolina, North Carolina, and Virginia. The migrant stream continues up the eastern seaboard states after June 15 to Pennsylvania, Maryland, New Jersey, and into New York after July 1. The eastern seaboard pattern states' agricultural harvest continues active into September and October when many Florida-based crews are used in apple harvest in Virginia and New York in in the late fall vegetable harvest in North and South Carolina and Virginia. We also have a significant migrant pattern to the midwestern states of Ohio, Indiana, and Michigan. This pattern has grown rapidly during the last five years with a total estimated migrant work force from Florida of approximately 8,500 workers. This pattern begins in July with vegetables and cherries and is completed in September with the Michigan apple harvest.

Information furnished by:

Farm Labor Department
Florida State Employment Service

MIGRANT HEALTH SERVICE REFERRAL SYSTEM

The Migrant Health Service Referral System has received less attention during this reporting period than previously, although 1,402 referrals were made and some conferences were held to discuss this system.

Efforts to realize final development and implementation of the system in the Atlantic states have been frustrated by the lack of an administrative mechanism to allow for the printing, distribution, general supervision, and follow-up of the system.

Even though there is general agreement among the participant states and the Migrant Health Program, regarding the desirability of final development of the referral system, this project has been unable to achieve such implementation to date. We hope to achieve it before the next annual report is prepared.

Without doubt, the system has proven itself; 53 per cent of the patients referred on this system received continuity of health care, the system has provided a valuable source of data regarding the health of migrants, the mobility of migrants, and the types of services available (and not available) to the migrants. More than 3,000 completed referrals await analysis at the present time.

A prototype of the final version of the referral form is on hand. Ten (10) Atlantic states participated in its development; plans have been developed to provide a single volume containing all of the health service indexes. We cannot move, however, beyond the present level of accomplishment until there is clearly designated and funded an administrative mechanism necessary to final implementation of the referral system. We expect to work toward this end and achieve some measure of success before year's end.

ANNUAL PROGRESS REPORT

PROJECT OBJECTIVES FOR - 1968 -

I. TO CONTINUE TO INCREASE MEDICAL SERVICES RENDERED TO THE MIGRANT POPULATION:

(a) BY THE INAUGURATION OF ADDITIONAL CLINICS, WHERE FEASIBLE.

(b) BY INCREASING THE NUMBER OF MIGRANT ATTENDEES AT EXISTING AND NEW CLINICS.

(c) BY INCREASING THE NUMBER OF PATIENT REFERRALS TO PHYSICIANS ON A FEE-FOR-SERVICE BASIS IN THOSE COUNTIES NOT OPERATING MIGRANT MEDICAL CLINICS.

I.a This item has been met to the extent that the limited funds permit. A new migrant clinic was opened in the Town of Oviedo in Sanford (Seminole County). The clinics planned for St. Lucie and Martin Counties were activated and are considered successful, after a rather faltering beginning. Broward, Lee, and Seminole Counties instituted planned parenthood clinics.

I.b The success attained toward meeting this part of the objective may be evaluated by comparing migrant medical clinic attendance (see county report forms) for this report period with the figures listed below for the 1966-67 report:

COUNTY HEALTH DEPARTMENTS	1966 - 67
Broward County	3,874
Collier County	887 *
Highlands County	NC **
Glades & Hendry Counties	1,181
Lee County	1,566
Manatee County	75
Martin County	NIO ***
Orange County	2,871
Polk County	467 *
Putnam & Flagler Counties	NA****
St. Lucie County	NIO ***
Sarasota County	451
Seminole County	1,823

* Excluding paratist and V.D. treatment, T.B. drugs, insulin, and birth control pills
** No Clinics
*** Not in Operation
**** Not Available

I.c To evaluate this portion of the objective, a comparison can be made between the figures listed in the appropriate county report forms for this report, with the 1966-67 figures:

COUNTY HEALTH DEPARTMENT	1966 - 67
Collier County	669
Highlands County	76
Polk County	NA****
Putnam & Flagler Counties	NA****

**** Not Available

II. TO CONTINUE TO INCREASE DENTAL SERVICES RENDERED TO THE MIGRANT POPULATION:

(a) BY RENDERING MORE COMPREHENSIVE DENTAL CARE RATHER THAN LIMITING CARE TO CASES OF AN EMERGENCY NATURE AS IN THE PAST.

(b) BY INCREASING THE NUMBER OF MIGRANT ATTENDEES AT EXISTING DENTAL CLINICS.

(c) BY INCREASING THE NUMBER OF PATIENT REFERRALS TO DENTISTS ON A FEE-FOR-SERVICE BASIS IN THOSE COUNTIES NOT OPERATING MIGRANT DENTAL CLINICS.

II.a This item was met in all but one county. Broward was unable to change its policy due to lack of necessary equipment and dentist clinician time. St. Lucie and Martin Counties experienced difficulties for several months after the clinics opened with faulty equipment and lack of some needed items. These problems have since been overcome. Lee County instituted dental clinics, offering comprehensive service starting in January, 1968.

II.b This item has been met in the limited number of counties offering migrant dental clinics. The clinic attendance in Broward rose from 1,054 in 1966-67 to 1,275 for 1967-68. New clinics were opened in Lee, Martin, and St. Lucie Counties.

II.c Referral figures contained in the county report forms for this year may be compared with the following figures for the counties concerned in the 1966-67 report to evaluate this part of the objectives:

COUNTY HEALTH DEPARTMENT	1966 - 67
Highlands, Glades & Hendry Counties	31
Lee County	35
Orange County	1
Sarasota County	51
Seminole County	171

III. TO INCREASE THE NUMBER OF COUNTIES PARTICIPATING IN THE MIGRANT PROJECT.

Due to fund limitations we were unable to meet this objective, and in fact, retrogressed as one of the participating counties (Alachua) withdrew from the project, effective the last day of 1967.

IV. TO ASSURE THAT THE GRANT PERIOD FOR THE COMING YEAR WILL GIVEN ON JANUARY 1, 1968, AND END ON DECEMBER 31, 1968.

This objective was met thanks to the wholehearted cooperation of the United States Public Health Service; especially the Regional Migrant Health Representative and the Grants' Officer.

NUTRITION SERVICES TO THE MIGRANT HEALTH PROJECT, 1967-1968

During 1967-68 there has been some increase in nutrition services provided to the families of migrant agricultural workers and to staff of health departments or other agencies providing health services. A major accomplishment was the recruitment of a well qualified and conscientious nutrition coordinator for the Statewide Migrant Health Project who assumed duties in February, 1968. His recruitment will make it possible to extend nutrition education services and diet counseling to more migrants and their families in 1968-69. To date the nutrition coordinator has concentrated on the following counties: Sarasota, Manatee, Polk, St. Lucie, Martin, Lee, and Collier. A nutritionist, assigned by the State Board of Health to Lee and Collier counties worked with the migrant health program in those counties and two State Board of Health regional consultants serving Seminole, Orange, Putnam and Flagler counties provided some nutrition information to migrant families and project staff in those areas. Nutrition needs and problems of the migrants were assessed by visits to the migrant camps, clinics, day care centers, and schools. Major nutrition problems observed are obesity, nutritional anemias, diarrheas, and nutritional needs related to pregnancy, child feeding and chronic diseases. Nutritionally inadequate food intakes are due to poor facilities for food preparation in available housing, inaccessibility to competetively priced food markets, undependable income, fatigue, lack of food preparation and home management skills and lack of education and motivation. The objective of the nutritionists is to improve the eating habits of the migrant families so that they will have a nutritionally adequate diet that they can afford and which will improve their health and well-being. To bring about this improvement, the nutritionists in the past year have been working in the following ways:

A. Giving culturally modified, basic instructions on the foods that meet nutritional needs to groups and individual migrants in the family health clinics and in the migrant schools.

B. Demonstrating easy and sanitary preparation of low-cost nutritious foods to groups of workers and their families at camps and clinics.

C. Providing diet counseling services to the maternity patients, mothers with young children, persons with diabetes or who are overweight, have heart conditions or any other disorders which the migrant clinic physician refers.

D. Offering consultation on nutrition and diet to professional and non-professional staff of county health departments, schools, day care centers, community action programs, church groups, and other interested groups to extend the nutrition education components of health and welfare services to the migrant and his family. Public health nurses, teachers, and community aides are workers most frequently involved.

Description of the specific nutrition services provided in each county can be obtained by referring to the individual county reports.

During the past year, allegations citing the nutrition problems among migrants in Collier County were made through the public press by the Citizen's Board of Inquiry into Malnutrition and Hunger. A follow-up to investigate these allegations was made by the Migrant Health Project Coordinator, Pediatric Consultant and the Director of the Division of Nutrition. Their report to the State Health Officer identified problems in housing, day care for young children and the variety of health conditions seen by county health departments. They did not find evidence of widespread nutritional deficiency diseases claimed to exist. Resources to meet food and health needs were available in the county and were being used. A commodity food distribution program in the county would be a desirable additional resource. The medical report of physical findings on the 23 children and infants of migrant families selected by the team from the Citizen's Board of Inquiry into Malnutrition and Hunger as being the most serious cases of "malnutrition" in the county showed 39 health problems. Of these, 11 cases of iron deficiency anemia (six borderline), and three cases of diarrhea were those that could be considered related to food.

These children initially treated at the examining hospital, Children's Variety Hospital in Miami, are now being followed at their county health department migrant clinic. As part of their care, the nutritionist has been making home visits to parents of these families in order to help improve the family eating pattern, especially to increase the consumption of foods high in iron and to emphasize sanitary food handling techniques.

To further reach migrant families, a pilot program providing training to aides employed by the Community Action Program is being conducted in Lee County. These aides, former migrants themselves, are being trained in family food management so that they may assist the migrant families with whom they work. After developing the teaching outline, visual aids and resource materials, this program will be offered to the aides of three other Community Action Programs in Florida. With the staff of the migrant school at Palmetto, Florida, a summer enrichment program for migrant children and their parents is being developed and evaluated. Students will be taught about the food needs of their families, consumer economics and given new experiences in preparing foods. The program, using a home economics teacher, brings in resource people from the Manatee County Health Department (nurse, sanitarian, and nutritionist). If the program is successful during the summer, then a full-time, year round program will be developed and offered to a much larger number of migrant children and their parents. It also might be tried in other areas.

To date the Nutrition Coordinator employed for the Statewide Migrant Health Project has had the opportunity to be oriented to the state and counties, to the migrant health program, and to some of the nutrition and health needs of seasonal farm workers. The first objective for 1968-69 is to prepare, with the other nutritionists serving project counties, a detailed nutrition program plan for counties participating in the Statewide Migrant Health Project. This plan will include long-range and short-term objectives, the identification of the nutritional needs of the migrants, and the use of current statistics as a baseline of the health and food habits of the migrants from which improvements in eating patterns and health status can be measured. In addition, suitable nutrition education materials are needed for use with migrant farm workers and their families. Materials will be prepared and pretested based on foods which are available, inexpensive and enjoyed. Materials must be easily understood, attractive and meaningful. Some areas for which teaching aids are being considered are family nutrition, child feeding and sanitary use of foods. Guidelines for food demonstrations and outlines and visual aids for group instruction will also be prepared.

In developing the program plan and plans for preparation for visual aids, it would be most helpful to have consultation and suggestions from staff of the Migrant Health Branch of the Public Health Service, as well as from the staff of the State Board of Health and county health departments participating in the Statewide Migrant Health Project. Four nutritionists from Florida, who had the opportunity to participate in the East Coast Migrant Health Conference, appreciated the exchange of ideas. They recognize more clearly the need for more uniformity among states in approaches and materials used in nutrition education and diet counseling so that migrant families will be helped and not confused. A working conference for nutritionists from various states with migrant health programs to plan for continuity of service and joint preparation of teaching aids including films, filmstrips, slides, tape recordings, etc. would improve nutrition education for migrant workers when they are in Florida.

FLORIDA MIGRANT SYPHILIS CASEFINDING PROJECT

Syphilis among migrant farm laborers has been a major problem of concern to Florida for many years. During fiscal year 1967, 256 primary and secondary and 143 early latent cases of syphilis were reported among the estimated 80,000 agricultural migrants in the state.

Generally, there are two types of migrants; the mainstream annual laborers and the temporary or casual laborers. The mainstream migrant usually resides in Florida from November through May and then is "on the stream" which extends up the eastern seaboard during the five summer months. He travels within or at the head of a family group which is attached to an informal, but highly organized, labor system supervised by crew chiefs or a large farm. The number of these people circulating in Florida during the season is estimated to be 30,000. Their racial composition is 42 per cent Caucasian, including 25 per cent Latin American, and 58 per cent Negro.

The temporary, or casual migrant is usually a young, single Negro male, having no definite line of travel and who is not a fully integrated part of the crew chief or large farm organization. He often drops off at the end of the Florida season and works in nearby urban areas at unskilled jobs. Numbering as many as 53,000 in a season, only their mobility and temporary agricultural work classify them as migrants.

A survey conducted in 1965 and epidemiologic results obtained during the fiscal year 1967 season have established the following facts:

1. The infectious syphilis rate as identified among migrants when in Florida is seven to eight times that of the general population.
2. Nearly 28 per cent of the migrant early syphilis morbidity from eight states on the eastern seaboard was attributed to Florida.
3. Approximately 66 per cent of Florida migrant early syphilis infections were acquired while in Florida.
4. There were but a few spread infections from Florida migrant early syphilis cases that were identified in other states.
5. There were 17 different states which were involved in the source/spread determinations of the migrant cases.

Also there was no evidence that there is frequent transmission of disease between the migrant population and the non-migrant population. Thus it is concluded that the large reservoir of infectious syphilis among migrants is largely self-contained and moves en masse out of Florida and heads into more splintered segments circulating throughout a number of states. Although 35 to 40 per cent of the disease is transmitted out of Florida, this may occur in as many as 20 different states. Therefore, any real impact to reduce the incidence among the migrants must be initiated in Florida where the splintered populations regroup for a period of seven months.

Because of the need for close epidemiologic surveillance of this group, the Florida

State Board of Health developed a special undertaking entitled, "Migrant Syphilis Casefinding Demonstration Project." In September, 1967, a team of four public health advisors and one coordinator were assigned to this project to work in the major migrant areas of Florida.

Their mission was as follows:

1. To identify syphilis cases among resident and non-resident migrant farm laborers.
2. To provide rapid and complete interviewing service to syphilis cases.
3. To apply epidemiologic treatment to all eligible contacts.
4. To identify the source and spread infections of early syphilis cases.
5. To identify the patterns of movement among migrants within the state.
6. To collect, analyze, and evaluate the epidemiological and sociological aspects of the venereal diseases among the migrant population.
7. To apply an intensive epidemiologic program in the major migrant areas in Florida and thereby decrease the migrant syphilis rate.

Since the inception of this special project (July, 1967 - March, 1968) the objectives, as outlined, have been pursued. The results to this point are as follows:

1. Two hundred, twenty-one cases of infectious and 105 cases of early latent syphilis have been identified.
2. Fourteen thousand, thirty-three blood tests have been obtained resulting in a 5 per cent reactor rate with subsequently 32 cases of primary and secondary, 38 cases of early latent, and 50 cases of late latent brought to treatment.
3. Forty-eight per cent of the migrant primary and secondary syphilis was a result of intensive syphilis epidemiology (interviewing and investigating). Seventeen per cent of the total primary and secondary cases volunteered to the clinic.
4. Sixty-five per cent of the not infected contacts at the time of initial examination were given epidemiologic treatment.
5. The probable source of migrant syphilis has been identified in 64 per cent of the cases.
6. The majority of the spread cases among those interviewed were in Florida.

It is still too early to determine any trend emerging from this project. The success or failure of Florida's syphilis casefinding among migrants will be reflected to a great extent on the contribution of migrant workers to interstate and intrastate syphilis transmission. According to reports this season, fewer syphilis cases have been reported among migrants in other states and as this trend continues, we must strive to provide close surveillance over Florida migrants to insure a continuing decline.

One of the major problems in migrant syphilis epidemiology is the inability to obtain satisfactory locating and identifying information on contacts and suspects. In view of Florida's experience with migrant syphilis casefinding, the following guidelines are recommended to those states having migrant syphilis patients:

1. Interviewers should be as thorough as possible in eliciting good locating and identifying information on migrant syphilis contacts. (The name of the crew chief and name of the camp is important in locating a contact.)

2. Contacts and suspects to early syphilis cases which are to be investigated in other jurisdictions should be transmitted as rapidly as possible.

3. All contacts to migrant syphilis cases and all contacts identified as migrants should be epidemiologically treated.

4. "Operation Pursuit" concepts, particularly case management, should be employed for each migrant syphilis case. Selective bloodtesting should be conducted in migrant camps and places where migrants congregate.

As the upward trend of early syphilis cases reverses in the migrant population, as well as the general population, a close surveillance over syphilis epidemiology and other program intelligence is necessary to insure a continuing decline.

Information furnished by:

Florida State Board of Health
Division of V.D. Control

MIGRANT DENTAL HEALTH PROGRAM
May 1, 1967 thru April 30, 1968

During this reporting year dental inspections were made of 575 children at the Markham Elementary School in Pompano Beach by a health team consisting of a dentist, dental hygienist, and public health nurse.

In addition to the dental inspections at this school, a dental health program was presented for the migrants.

Dental health programs consisting of toothbrush demonstrations and a dental health film were presented to ten schools in the following counties: Martin, Polk, Seminole, and Sarastoa. These programs were conducted by the state dental hygienist. All of these schools have migrant children enrolled.

COUNTY	NUMBER OF SCHOOLS	NUMBER OF DENTAL INSPECTIONS	PROGRAM CONDUCTED
Broward	2	575	Dental health education, films, toothbrush demonstrations
Seminole	2	-	Same as above
Polk	2	-	Same as above
Sarasota	1	-	Same as above
Martin	3	-	Same as above

Information furnished by:

Bureau of Dental Health
Florida State Board of Health

ANNUAL PROGRESS REPORT

HEALTH EDUCATION

I. General Description of Health Education Service:

A. Staff involved:

1. Professional health educator. The health educator on the migrant health project works out of the state office covering the fifteen counties covered in the "state" migrant health project. Two of the county health departments have a health educator on the general county health department staff.

2. Other kinds and whether paid or volunteer. All migrant health project personnel are engaged in health education to some extent. This includes public health nurses and sanitarians in particular, but also includes all other project personnel and in addition, many of the other county health department personnel as they work with the migrant population. Volunteer help is not significant.

B. Specific objectives and duties:

1. To develop methods and encourage efforts exerted toward the reduction of the number of preventable illnesses and accidents associated with the low standards of sanitation, nutrition, child care, and general health care among the migrant population and to increase the well-being of this group.

2. To increase the knowledge among migrants of:

   a. The various community health resources,
   b. The generally recommended health practices in sanitation, nutrition, child care, and general health.

3. To develop methods and encourage efforts toward transferring present knowledge as well as new knowledge into better health habits and practices of the migrant.

4. To inform the general community of the health and other social problems of the migrants in the hope of constructive action toward solution of these problems.

C. Relationships with other project staff, migrants, growers, and others.

The relationship of the health educator is that of consultation to the local health department staff from the state project office. Contacts with individual migrants, growers, and others of the local community are made with county health department personnel to avoid potential conflict or overlapping of efforts. Direct contacts are made only on request or with approval.

Consultations were held with all county health department medical directors, project nurses, sanitarians, and clerical personnel, both in county health department offices and in the various clinics. Migrant contacts were made in the clinic settings, in homes, and some in the fields. Growers were met at area conferences, packing sheds and in the field. Local contracting hospitals were contacted for further clarification of the inpatient migrant hospital program. These contacts provided information on the needs for health education, what is being accomplished with present personnel and methods and they also provided a basis for suggested methods of improving health education procedure.

D. Consultation or other assistance obtained from outside project - type and source.

1. Health Education Workshop, the Migrant Health State Conference and the Eastern States Regional Conference provided orientation in health education and valuable contacts with personnel outside Florida. These have produced follow-up correspondence to add to our plans the successful experience of other programs. This includes health education and project personnel in California, Ohio, Oregon, Kansas, North Carolina, New York, New Jersey, and Virginia.

2. Pertinent literature from libraries and allied personnel.

3. Contacts with regional and federal project personnel.

E. Consultation needed.

Some form of centralized collection and distribution of health education methods and results is needed. In very recent history, growing and more knowledgeable efforts are being made in migrant health education. Those working in this field need to be kept currently informed on successful efforts as they are made in all projects - thus increasing the successful production of modern health practices within the migrant group.

II. Description of Services Provided:

A. Local county health department area:

1. Visit, survey, study, and analyze local situations for needs, present procedures and methods of improving health education efforts. General consultation to local county health department staff.

2. Inform and make available resource material from the state office, including films, literature, leaflets, etc.

   a. Screen audio-visual material for particular use for subject and audience.
   b. Read literature and have samples available for local use.

3. Present suggested methods of improving health educational efforts to local county health departments for comments and discussion.

4. Encourage and assist in implementation of approved methods of improvement in health education.

5. Contact county health department and local hospital personnel as required for inpatient hospital form processing.

B. State Office:

Assist, as requested by Assistant to the Project Director, in budget and Annual Progress Report preparation and also process inpatient hospitalization forms.

C. Out-of-State:

Consultation with personnel of other Migrant Health Projects, regional office, and federal personnel through meetings and conferences - as well as direct correspondence on particular needs or concerns.

D. Individual:

1. Personal contacts with migrants in the clinics, in the homes, and in the field.

2. Contacts with growers and processers at conferences, packing plants, and in the field.

3. Contacts with community or other agencies; including farm labor offices, local schools, self-help housing, community action organizations, and local non-health department officials.

E. Preparation of new plan of operation for health education in the migrant health project:

This plan is designed to incorporate recommendations in consultation with the local project health units resulting in cooperative efforts toward more positive and productive action, with lasting results for the improvement of the health condition of the migrants in the state.

III. Appraisal of Effectiveness of Educational Effort:

A. Kinds of problems overcome and in what ways:

1. Need for better understanding of the local situations:

Overcome by conferences with medical officers and health department personnel, visits to clinic sites and observation of their operation, and by visits to the migrant communities and the camps to learn the composition and location of the local migrant.

2. Need for better understanding of available material:

Overcome by previewing and grading of pertinent films and by a study of literature pamphlets, posters, etc.

3. Need for equipment for field use:

Equipment has been purchased, including a camera, carousel projector, and tape recorder. There should assist us in preparing and presenting material at the local level.

4. Need for better understanding of the mechanism of the program:

   Overcome by working under the direction of the assistant to the project director on budget preparation and inpatient hospital statement preparation.

B. Kinds of problems which hindered effectiveness of program, and that remain to be solved:

1. Lack of personnel at local level.

   For most effective use this would require use of migrant aides and additional funds. In the absence of funds, other measures must be used.

2. Lack of time of present personnel.

   Professional personnel are, of necessity, occupied in their own professional areas.

3. Migrants living in many dispersed areas.

   Migrant aides could locate and bring these families out.

4. State migrant health office has no film projector for field use. This requires the use of local equipment which may or may not be available.

5. Belief in health education.

   Health education needs to begin with health personnel to convince them that the migrant can learn to improve his own health situation and that implementation of the program provided will lead to his self-improvement.

IV. Specific plans for future objectives, procedures, relationships, etc.

The health educator will continue to consult with local health department migrant personnel leading (hopefully) toward increased efforts in health education. Any possibilities of assistance to present personnel at the local level (not involving additional funds) will be encouraged. This will include other agencies, interested community people, volunteer personnel or available government programs. Where new sources of personnel are found, the role of the health education will continue to be as consultant to the local county health departments with full cooperative efforts, but more direct fortification may be necessary to supplement local available time.

It is hoped that the needs of health educational efforts will become recognized so that migrant people themselves may become a part of the local health team - giving of their ability to learn the essentials of "the generally recommended health practices" and of communicating these essentials to their community to the end that works change to action and vision to reality.

Continue to strive to find procedures used in other programs successfully which can be adapted to our program.

Cooperate with other programs in sharing information.

Specific Objectives:

1. To find methods and encourage efforts exerted toward the reduction of the number of preventable illnesses and accidents of the migrant agricultural population.

2. To bring to the migrant knowledge of the generally recommended health practices and the health resources available to make these practices usable.

3. To find methods and encourage efforts to transfer new and old knowledge of health practices to better habits and action for health of the migrant.

4. To inform the general community of the health and the other social problems of the migrants.

Information furnished by:

Health Educator
Migrant Health Project

GENERAL SANITATION EXHIBITS

In the Sanitation Section of many of the county reports, reference is made to Chapter 170C-32 of the Sanitary Code of Florida, House Bill No. 269, and the Camp Inspection Form. For the purpose of eliminating duplication, these materials (concerned with migrant camps) are reproduced on the following 13 pages.

RULES OF THE STATE BOARD OF HEALTH

THE SANITARY CODE OF FLORIDA

CHAPTER 170C-32

CAMPS

170C-32.01 Camps - general (381.031(1)(g)3.F.S.)
170C-32.02 Definitions (381.031(1)(g)3.F.S.)
170C-32.03 Notice of construction (381.031(1)(g)3.F.S.)
170C-32.04 Permit for operation (381.031(1)(g)3.F.S.)
170C-32.05 Application and issuance of permit (381.031(1)(g)3.F.S.)
170C-32.06 Revocation of permit (381.031(1)(g)3.F.S.)
170C-32.07 Camp sites (381.031(1)(g)3.F.S.)
170C-32.08 Shelters (381.031(1)(g)3.F.S.)
170C-32.09 Water Supply (381.031)(1)(g)3.F.S.)
170C-32.10 Garbage and refuse disposal (381.031)(1)(g)3.F.S.)
170C-32.11 Insect and rodent control (381.031(1)(g)3.F.S.)
170C-32.12 Heating (381.031(1)(g)3.F.S.)
170C-32.13 Lighting (381.031(1)(g)3.F.S.)
170C-32.14 Excreta and liquid waste disposal (381.031(1)(g)3.F.S.)
170C-32.15 Plumbing (381.031(1)(g)3.F.S.)
170C-32.16 Toilets (381.031(1)(g)3.F.S.)
170C-32.17 Washrooms, bathrooms and laundry tubs (381.031(1)(g)3.F.S.)
170C-32.18 Food service facilities (381.031(1)(g)3.F.S.)
170C-32.19 Beds and bedding (381.031(1)(g)3.F.S.)
170C-32.20 Fire protection (381.031(1)(g)3.F.S.)
170C-32.21 Sanitary maintenance of premises (381.031(1)(g)3.F.S.)
170C-32.22 Responsibility of camp operator (381.031(1)(g)3.F.S.)
170C-32.23 Camp supervision (381.031(1)(g)3.F.S.)
170C-32.24 Responsibility of occupants (381.031(1)(g)3.F.S.)

170C-32.01- Camps - general - Sanitary practices relating to construction, operation and maintenance of migrant labor, recreation and other camps. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.422-.482 FS)

170C-32.02 Definitions - (1) "Camp" - One or more buildings or structures, tents, trailers or vehicles, together with the land appertaining thereto used as living quarters for fifteen (15) or more persons, including children, whether or not rent is paid or reserved in connection with the use or occupancy of such premises. Included are camps operated for recreational, educational and other purposes and labor camps established for the permanent or temporary housing of farm laborers or other workers; provided, that this definition shall not apply to forestry or tobacco farm operation.

(2) "Person" - An individual or group of individuals, association, partnership or corporation.

(3) "Camp operator" - The person who has been granted a permit in

accordance with these regulations to operate a camp.

(4) "Shelter" - Any building of one or more rooms or tents or trailers used for sleeping or living quarters at a camp.

(5) "Habitable room" - A room or enclosed floor space used or intended to be used at a camp for living, sleeping, cooking or eating purposes excluding bathrooms, water closet compartments, laundries, pantries, foyers, connecting corridors, closets or other storage space.

(6) "Toilet facilities" - Water closets, privies, urinals and the rooms provided for the installation of these units.

(7) "Refuse" - Solid waste except body wastes, including garbage, rubbish and ashes.

(8) "Garbage" - Waste products of all animal or vegetable matter resulting from growing, processing, marketing and preparation of food items, including containers in which packaged.

(9) "Sanitary landfill" - A planned method of compacting and completely covering garbage in a prepared area so as to prevent sanitary nuisances and insect and rodent breeding and harborage.

(General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.422. FS)

170C-32.03 Notice of construction - Each person who is planning to construct or enlarge for occupancy or use a camp or any portion of facility thereof, or to convert a property for use or occupancy as a camp shall give notice in writing of his intent to do so to the board at least fifteen (15) days before the date of beginning such construction, enlargement or conversion. The notice shall give the name of the city, village, town or county in which the property is located, the location of the property within that area, a brief description of the proposed construction, enlargement or conversion and the name and mail address of the person giving the notice and his telephone number, if any. Upon receipt of such notice the board shall send promptly to the person giving notice copies of the state law and regulations issued thereunder applicable to camps. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 381.472. FS

170C-32.04 Permit for operation - Before any person shall either directly or indirectly operate a camp he shall make an application for and receive from the board a valid permit for operation of the camp. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) s FS, 381.432 FS)

170C-32.05 Application and issuance of permit - Application for such permit shall be made in writing to the board through the local health department on a form provided for this purpose at least fifteen (15) days prior to commencement of camp operation. The application shall include the name and address of the camp owner, name and address of the person requesting a permit to operate the camp, the location of the camp, the approximate period during which the camp is to be operated and such other pertinent information as the board shall find necessary. A separate application shall be submitted for each camp and a separate permit shall be issued annually for each such camp. If the board finds after investigation that the camp or proposed operation thereof conforms or will conform to the minimum standards required by these regulations, they shall issue a permit for operation of the camp. The permit, unless sooner revoked, shall expire on June 30 next after the date of issuance. The permit shall not be transferralbe or assignable. In the event of a change of operator of a camp, the new operator shall immediately file an application for permit in accordance with provisions of this section.

(General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.442 FS; 381.452 FS)

170C-32.06 Revocation of permit - A permit may be revoked at any time if the board finds the camp for which the permit is issued is maintained, occupied or operated in violation of law or any regulations applicable to a camp or in violation of a condition stated on the permit. In case of a revocation of permit the camp operator may make application for a new permit by complying with the provisions of Section 170C-32.05 of this chapter. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.462 FS)

170C-32.07 Camp sites - (1) All camp sites shall be well drained and free from depressions in which water may stand. No camp shall be located in or immediately adjacent to marshes, bottom lands, or other potential mosquito breeding areas unless adequate board approved safeguards or preventative measures are taken. Natural sink holes, swamps, pools or other surface collectors of water within two hundred (200) feet of the periphery of the camp shall either be drained or filled to remove quiescent surface water except that such areas containing water not subject to such drainage or filling shall be treated with oil or other larvacide as necessary to prevent the breeding of mosquitoes.

(2) No camp shall be located on a site which is subject to or may cause extreme traffic or other hazards unless acceptable safeguards are provided.

(3) No camp shall be located on the watershed of a domestic or public water supply so as to create a pollution hazard.

(4) No camp structure shall be located less than two-hundred (200) feet from barns, pens or similar quarters of livestock or poultry.

(5) All camp sites shall be adequate in size to permit locating of buildings so as to minimize the hazards of fire.

(6) All camps shall provide space for recreation commensurate with the purpose of the camp, the size of the camp and the type of occupancy. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.08 Shelters - (1) Shelters in all camps shall be structurally sound and shall provide protection to the occupants against the elements. At least one-half (½) of the floor area of each habitable room shall have a minimum ceiling height of seven (7) feet. Floors of the buildings used as living quarters shall be constructed of wood, concrete or other comparable material. Wooden floors shall be of tight durable construction with a smooth finish and in buildings without a cellar or basement, shall be elevated not less than eighteen (18) inches above the average ground level to permit free circulation of air.

(2) All concrete floors shall be smooth finished and the floor level shall be not less than twelve (12) inches above the average ground level.

(3) All rooms designed or used for sleeping purposes shall provide a minimum of three-hundred (300) cubic feet of air space for each occupant. In computing the cubic footage of sleeping rooms, ceiling heights shall be counted to a maximum of nine (9) feet and no floor area shall be counted where the ceiling height is less than six (6) feet. In a house-trailer furnished by a person other than the occupants there shall be a minimum of twenty (20) square feet of clear floor area for each person sleeping therein.

(4) All shelters hereafter constructed or remodeled for family living quarters shall contain a minimum of seventy (70) square feet of floor space

for the first occupant and fifty (50) square feet of floor space for each additional occupant. Sleeping rooms in such family quarters shall also meet air space requirements of this section.

(5) Separate sleeping quarters shall be provided for each sex except in the housing of families.

(6) Each habitable room shall have at least one (1) window or skylight opening directly to the outside. The minimum total window area shall be ten (10) per cent of the floor area of each room. When the only window in a room is of the skylight type located in the roof of the building, the total window area shall be fifteen (15) per cent of the floor area of such room. At least one window or skylight shall be easily opened for ventilating the room. The total openable window area shall equal at least forty-five (45) per cent of the minimum window area required for a room except where board approved mechanical ventilation is provided. In computing total window area and openable window area, jalousie doors may be counted. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.09 Water Supply - (1) An adequate and convenient supply of water that conforms with the requirements of Chapter I of this code shall be available at all times in each camp for drinking, culinary, bathing and laundry purposes.

(2) The water supply shall provide at least thirty-five (35) gallons per person per day to the camp site.

(3) Adequate facilities for providing hot water for bathing and dishwashing purposes shall be available.

(4) In existing camps with water pressure systems, water outlets shall be located in such manner that no shelter or habitable area is more than one-hundred (100) feet distance from such an outlet. Drainage facilities shall be provided for the overflow or spillage from such outlets.

(5) In all camps hereafter constructed water under pressure shall be supplied to all buildings housing family living quarters and all other buildings in which cooking is permitted or which contain facilities for bathing, laundering or dishwashing.

(6) Where water is distributed under pressure a supply rate at least two and one half (2½) times the average hourly demand shall be possible and the distribution line shall be capable of supplying water at normal operating pressure to all fixtures.
(General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.10 Garbage and refuse disposal - (1) All garbage, kitchen wastes and other refuse shall be deposited in metal cans with tight fitting metal coverings not to exceed twenty (20) gallons capacity. Such cans shall be conveniently located to all households throughout the camp area and shall be provided in sufficient number to handle all refuse from the camp.

(2) The contents of said cans shall be emptied and the cans cleaned as often as necessary to keep them and their surroundings in a sanitary condition.

(3) Provisions shall be made for disposing of the garbage, kitchen wastes and other refuse by incineration, grinding, burial or incorporation in a sanitary landfill.
(General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.11 Insect and rodent control - (1) Effective measures shall be taken to control rats, flies, mosquitoes and bed bugs and other insect vectors or parasites within the camp premises.

(2) No standing water shall be allowed to pool in the vicinity of the camp and the premises shall be kept clear of cans, rubbish and other articles that will hold water.

(3) No accumulation of materials shall be allowed that will breed flies.

(4) All windows, screens doors and outside openings in any camp shelter shall be protected with wire fly screening of not less than sixteen (16)-mesh. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.12 Heating - (1) When a camp is located in an area where prolonged temperatures below seventy degrees fahrenheit (70°F) are normally experienced during the period of camp occupancy, adequate heating equipment shall be installed in all living quarters.

(2) A stove or other source of heat shall be installed and vented in such a manner to avoid both a fire hazard and a dangerous concentration of fumes or gas. In rooms with wooden or combustible flooring, there shall be a concrete slab, metal sheet or other fire resistant material on the floor under every stove extending at least eighteen (18) inches beyond the perimeter of the base of the stove. Any wall or ceiling, not having a fire resistant surface within twenty-four (24) inches of a stove or stove pipe, shall be protected by a metal sheet or other fire resistant material. Heating appliances, other than electrical, shall be provided with a stove pipe or vent connected to the applicance and discharging to the outside air or chimney. Such chimney shall extend two (2) feet above the peak of the roof. A vented metal collar shall be installed around the stove pipe, vent or flue in a wall, ceiling, floor or roof through which the stove pipe, vent or flue passes.

(3) Automatically operated heat producing equipment shall be provided with controls to cut off the fuel supply upon the failure or interruption of flame or ignition or whenever a predetermined safe temperature or pressure is exceeded. All steam and hot water systems shall be provided with safety devices designed to prevent hazardous pressures and excessive temperatures. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.13 Lighting - Where electric service is available each habitable room in a camp shall be provided with at least one ceiling type light fixture and a separate double electric wall outlet. Other rooms in which people congregate, laundry rooms, shower rooms and toilet rooms shall be provided with a minimum of one ceiling or wall type fixture.. Electric wiring shall be installed in accordance with the provisions of local electrical ordinance or if no such ordinance exists, in accordance with the provisions of the National Electrical Code. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.14 Excreta and liquid waste disposal - (1) Facilities shall be provided and maintained in all camps for the satisfactory disposal or treatment and disposal of excreta and liquid waste.

(2) Such facilities shall be maintained in compliance with provisions of Chapter VI of the code. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.15 Plumbing - All plumbing shall be in compliance with provisions of Chapter VII of this code or local plumbing ordinances whichever establishes the higher standards. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.16 Toilets - (1) Approved toilet facilities adequate for the capacity of the camp shall be provided.

(2) Each toilet room shall be so located that no individual is required to pass through a sleeping area, other than his own, in order to use toilet facilities. Toilet rooms shall have a window area of not less than six (6) square feet opening directly to the outside. No flush toilet fixture or urinal shall be located in a sleeping room.

(3) A toilet facility shall be located within two-hundred (200) feet of the door of each sleeping room. No privies shall be closer than fifty (50) feet from any sleeping room, dining room, mess hall or kitchen. Privies shall comply with the requirements of Chapter IV of this code.

(4) Where the toilet facilities are shared such as in multi-family dwellings and in dormitory type facilities separate toilet rooms shall be provided for each sex. These rooms shall be distinctly marked "For Men" and "For Women" by signs printed in english and in the native language of the persons occupying the camp. If the facilities for each sex are in the same building they shall be separated by a solid wall or partition extending from the floor to the roof or ceiling.

(5) Where toilet facilities are shared the number of water closets or privies provided for each sex shall be based on the maximum number of persons of that sex which the camp is designed to house at any one time, in the ratio of one (1) such unit to each fifteen (15) women and one (1) such unit to each twenty (20) men within a minimum of two (2) units for any shared facility. Family living accommodations containing private toilet facilities shall not be considered when establishing this number of shared toilet facilities.

(6) Urinals shall be provided on the basis of one for each twenty-five (25) men. The wall and floor space to a point of one (1) foot in front of the urinal lip, four (4) feet above the urinal and one (1) foot to each side of the urinal shall be faced with a non-absorbent material.

(7) Every water closet or flush toilet hereafter installed shall be located in a toilet room and shall be properly connected to a satisfactory disposal system which complied with the requirements of Chapter VI of this code. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.17 Washrooms, bathrooms and laundry tubs - (1) Approved washing, bathing and laundry facilities adequate for the capacity of the camp shall be provided.

(2) Where they will be used by more than one (1) family or by non-family group, separate washrooms and bathrooms conveniently located shall be provided for each sex. Each separate facility shall be plainly designated "For Men" and "For Women". If the facilities for each sex are in the same building they shall be separated by solid walls or partitions extending from the floor to the roof or ceiling. Washrooms and bathrooms provided in family living accommodations shall be partitioned off from the rest of the room. Provisions shall be made for adequate dressing space adjacent to bathing facilities.

(3) Where wash-basins and shower baths are shared, wash-basins shall be provided in the ratio of one (1) for every twenty (20) persons and shower baths shall be provided with one (1) shower head for every twenty (20) persons or fraction thereof. All shower and wash fixtures shall be

provided with both hot and cold water under pressure.

(4) A two (2) - compartment stationary laundry tub or tray or other laundry facility for every twenty-five (25) families or fraction thereof shall be provided for laundry purposes and shall be convenient to all living quarters. Water under pressure shall be provided at each laundry tub or tray. Laundry facilities shall not be used for kitchen waste disposal. Laundry waste shall be disposed of in accordance with the requirements of Chapter VI of this code or in some other sanitary manner approved by the board.

(5) Family living accommodations containing private washrooms, bathrooms and laundry tubs shall not be considered when establishing the required number of shared facilities.

(6) The floors of toilet facilities shall be of smooth but non-skid finish and impervious to moisture and sloped to drain. Floor drains properly trapped shall be provided in all shower baths and shower rooms to remove waste water and facilitate cleaning. The walls and partitions of shower rooms shall be smooth and impervious to moisture. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.18 Food service facilities - (1) In camps where individuals or families are permitted or required to cook within their living quarters, stoves shall be installed in accordance with provisions of sub-section 170C-32.12(2) of this chapter. Conveniently located facilities, consisting of sinks supplied with hot and cold water under pressure in a ratio of one (1) to ten (10) persons or one (1) to two (2) families shall be provided. Provision shall be made for safe storage and refrigeration of food.

(2) In camps where cooking facilities are used in common, the kitchen shall be screened with wire fly screening of not less than sixteen (16)-mesh. Stoves, installed in accordance with provisions of sub-section 170C-32.12 (2) of this chapter, and sinks, supplies with hot and cold water under pressure, shall be provided in a ratio of one (1) to ten (10) persons or one (1) to two (2) families. Provision shall be made for safe storage and refrigeration of food.

(3) All shelters hereafter constructed or remodeled for family living quarters shall provide a stove installed in accordance with provisions of sub-section 170C-32.12(2) of this chapter, a sink supplied with hot and cold water under pressure and a refrigerator capable of maintaining temperatures below fifty degrees fahrenheit (50°F); provided, that this sub-section shall not apply in camps which limit all food preparation and service to central mess or multi-family feeding operations conducted in accordance with provisions of sub-section (4) below.

(4) In camps where there is a central mess or multi-family feeding facility such as a dining room or mess hall, it shall be operated in compliance with Chapter XVI of this code except where the type of service is limited as so described in sub-section (5) below.

(5) Camps operating field kitchens shall be inspected and approved by the board and shall comply with the following minimum requirements:

(a) Food preparation equipment, eating utensils and service facilities shall be so made or constructed as to be easily cleaned and shall be maintained in a safe and sanitary condition at all times.

(b) Cleaning and bactericidal treatment of utensils and equipment shall be performed in accordance with the provisions of Chapter XVI of this code.

(c) Field kitchens, dining rooms, mess halls and other areas where food is prepared or served shall be screened with wire screening of not less than sixteen (16)-mesh. All screen doors shall be self closing and open outward.

(d) Adequate provision shall be made for the sanitary storage and protection of food supplies and adequate refrigeration and equipment, capable of maintaining temperatures below fifty degrees fahrenheit (50°F) shall be provided for the storage of meat, milk and other perishable foods. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.19 Beds and bedding - (1) Sleeping facilities shall be provided for each camp occupant. Such facility shall consist of beds, cots or bunks complete with springs and shall include clean mattresses and mattress covers or mattress ticks filled with clean straw or other suitable material free from dust or burlap. Mattresses, mattress ticks, blankets and other bed coverings provided by the camp operator shall be laundered or otherwise sanitized between assignment to different camp occupants.

(2) All sheets, pillowcases, blankets or other bed coverings provided by the camp operator shall be kept and maintained in a sanitary condition by camp occupants.

(3) Regular inspection of beds and bedding shall be made to insure freedom from vermin. Bedding shall be treated with an insecticide as necessary to prevent vermin infestation. When vermin are found or reported, effective extermination measures shall be undertaken immediately.

(4) Every bed, cot or bunk shall have a clear space of at least twelve (12) inches from the floor. There shall be a clear ceiling height of not less than thirty-six (36) inches above any mattress and there shall be a clear space of not less than twenty-seven (27) inches between the top of the lower mattress and the bottom of the upper bunk of a double deck facility. Triple deck facilities shall be prohibited and in sleeping rooms provided for other than family groups, double beds shall be prohibited.

(5) Single beds, cots or bunks shall be spaced not less than thirty (30) inches laterally or end to end and double deck facilities shall be spaced not less than thirty-six (36) inches laterally or end to end. A minimum of four (4) feet of clear aisle space shall be provided in all barracks and dormitories. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.20 Fire protection - All buildings in which people sleep or eat shall conform to the requirements established by the laws of this state and regulations or standards issued by the state fire marshall. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.21 Sanitary maintenance of premises - All tents, buildings, shelters or other structures and the entire premises of the camp shall be maintained in a clean, safe and sanitary condition, free from rubbish, waste paper, garbage and other refuse. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.22 Responsibility of camp operator (1) The camp operator shall be responsible for complying with all statutory requirements and regulations issued thereunder relating to camps and with all conditions stated in the permit issued to him under these regulations.

(2) The permit required under these regulations shall be posted and kept in a conspicuous place in the camp by the camp operator.

(3) The camp operator himself shall inspect daily or provide a competent individual to inspect daily the grounds and common-use spaces of buildings, structures or tents including toilets, showers, laundries, mess halls, dormitories, kitchens or any facilities relating to the operation of the camp and see that each is maintained in a clean and orderly condition and that the buildings are kept in good repair.

(4) The camp operator shall inform himself of the rules and regulations relative to the reporting and control of communicable diseases adopted by the board and shall comply with the pertinent requirements thereof.

(5) It shall be the duty of the camp operator, where no physician is in attendance at the camp, to report immediately to the local health department in the county where the camp is located any person in the camp affected with any disease designated as reportable in the rules and regulations of the control of communicable diseases adopted by the board and to insure the complete isolation of such person.

(6) There shall be adequate medical and nursing care at or available to all camps.

(7) No person known to be infected with any disease in a communicable form or to be a carrier of such disease shall be employed in the operation of maintenance of a camp. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.23 Camp supervision - All camps housing fifty (50) or more persons shall be supervised by a qualified resident supervisor who may be the camp operator or the camp operator's agent or employee. All camps housing less than fifty (50) persons shall be supervised and regularly inspected by the camp operator or his designated agent or employee. All persons designated as camp supervisors shall be jointly responsible with the camp operator for the sanitary condition of the camp. The name(s), telephone number, address or instructions how to locate the camp operator and supervisor shall be kept posted in a prominent location in the camp at all times. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 (FS)

170C-32.24 Responsibility of occupants - Every occupant of the camp shall use the sanitary and other facilities furnished for his convenience and shall comply with all applicable camp regulations which may concern or affect his conduct. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

CHAPTER 59-476

HOUSE BILL NO. 269

AN ACT relating to the State Board of Health; defining migrant labor camps; requiring that such camps be licensed; providing for the application, issuance and revocation of license; authorizing the board to issue regulations; providing for right of entry; and setting an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF FLORIDA:

Section 1. Definitions. - The following words and phrases shall mean:

(1) Migrant labor camp. One (1) or more buildings or structures, tents, trailers, or vehicles, together with the land appertaining thereto, established, operated or used as living quarters for fifteen (15) or more seasonal, temporary or migrant workers whether or not rent is paid or reserved in connection with the use or occupancy of such premises, provided however, this definition shall not apply to forestry or tobacco farm operation.

(2) Board: The State Board of Health.

Section 2. License required for establishment, maintenance or operation of migrant labor camp. - No person shall establish, maintain or operate any migrant labor camp in this state without first obtaining a license therefor from the board and unless such license is posted and kept posted in the camp to which it applies at all times during maintenance or operation of the camp.

Section 3. Application for license. - Application for a license to establish, operate or maintain a migrant labor camp shall be made to the board in writing and on a form and under regulations prescribed by the board. The application shall state the location of the existing or proposed migrant labor camp, the approximate number of persons to be accommodated, the probable duration of use and any other information the board may require.

Section 4. Issuance of license. - If the State Health Officer is satisfied, after causing an inspection to be made, that the camp meets the minimum standards of construction, sanitation, equipment and operation required by regulations issued under Section 6 of this act, he shall issue in the name of the board the necessary license in writing on a form to be prescribed by the board. The license, unless sooner revoked, shall expire on June 30 next after the date of issuance unless renewed, and it shall not be transferrable. All applications for renewal shall be filed with the State Health Officer thirty (30) days prior to its expiration on form blanks furnished by the board.

Section 5. Revocation of license. - The State Health Officer may revoke a license authorizing the operation of a migrant labor camp if he finds the holder has failed to comply with any provision of this act or of any regulation or order issued hereunder.

Section 6. Authority to issue regulations. - The board shall make, promulgate and repeal such rules and regulations as it may determine to be necessary to protect the health and safety of persons living in migrant labor camps, prescribing standards for living quarters at such camps, including provisions relating to construction of camps, sanitary conditions, light, air, safety, protection from fire hazards, equipment, maintenance and operation of the camp and such other matters as it may determine to be appropriate or necessary for the protection of the life and health of occupants. Regulations adopted hereunder shall be a part of the Sanitary Code of Florida created by 381.031 (1) (g) 12. and may be enforced in the manner provided in 381.031 (4), and violations thereof shall be subject to the penalties provided in 381.411.

Section 7. Right of entry. - The board and/or its inspectors may enter and inspect migrant labor camps at reasonable hours and investigate such facts, conditions, and practices or matters, as may be necessary or appropriate to determine whether any person has violated any provisions of this chapter or rules and regulations of the board pertaining hereto are being violated. The board may from time to time at its discretion publish the reports of such inspections in its monthly bulletin.

Section 8. Effective date. - This act shall take effect immediately upon its becoming law.

Approved by the Governor June 19, 1959.

Filed in Office Secretary of State June 20, 1959.

INSPECTION FORM - CAMPS

(AUTHORITY: Chapter 381, Section 381.422 - 381.482 Florida Statutes and Chapter 170C-32, Florida State Sanitary Code)

Date________________ Permit No.________________

Number of Occupants________________
Name________________
Owner________________
Address________________

Location________________
Person in charge________________
Address________________

1. CAMP SITE

Adequate drainage________________
adequate size________________
approved location________________
____

2. SHELTER

Structurally sound________________
All openings properly screened________________
Approved floor elevation & construction
____
Floor space adequate________________
Approved ceiling height________________
Adequate ventilation________________
Window area adequate________________
Air volume in sleeping quarters adequate________________
Adequate beds provided________________
Beds of proper design and adequately spaced________________
Beds and bedding properly maintained & vermin free________________
____

3. HEATING AND LIGHTING

Heating adequate, if needed________________
Heating facilities properly installed________________
____
Approved wiring________________
Adequate illumination________________
____

4. FIRE PROTECTION

Adequate fire control measures________________
____

5. FOOD SERVICE

Central mess and/or field kitchen facility________________
Attach separate inspection report - per Chapter 170C-16. When provided common kitchen facilities properly screened________________
________________;
Stoves and sinks adequate________________;
Adequate supply of hot and cold water under pressure________________;
Provision for safe food storate and refrigeration________________;
Properly maintained________________
Where provided, individual or family kitchen facilities adequate________________
____

6. WATER SUPPLY

Adequate and approved supply and distribution________________
Adequate hot water for bathing and dish washing________________

7. SANITARY FACILITIES

Properly located________________
Adequate Toilets________________
Adequate Urinals________________
Adequate Lavatories________________
Adequate Showers________________
Separate facilities provided for each sex in central units________________
Properly identified________________
Adequate window area________________
Area and fixtures clean and properly maintained________________
Privies comply with Chapter 170C-4________________
____
Satisfactory laundry facilities________________
____

8. PLUMBING

Comply with Chapter 170C-7 or local Code________________
Properly operating and maintained________________
____

9. SEWAGE DISPOSAL

Approved design & capacity________________
Satisfactory operation________________
____

INSPECTION FORM - CAMPS
(Continued)

10. GARBAGE AND TRASH DISPOSAL

Adequate number of approved cans______

Collection and disposal satisfactory__

11. PEST CONTROL

Satisfactory rodent and insect control

12. GENERAL

Premises properly maintained__________

Daily Inspection provided__________

Resident camp supervisor provided______

Adequate medical and nursing care available__________

Adequate communicable disease control and knowledge__________
and measures__________

An inspection of this camp has been made this date. Your attention is called to those items not in compliance with provisions of Chapter 170C-32, Florida State Sanitary Code. Satisfactory compliance must be made within ______ days or your permit will be subject to revocation.

Copy of Inspection report received________________________________
(Owner, Manager, Person In Charge)

Sanitarian______________________ ____________________County Health Dept.

FLORIDA STATE BOARD OF HEALTH

SAN 435 (Rev. 5/62)

BROWARD COUNTY HEALTH DEPARTMENT

Paul W. Hughes, M. D., Director

Area of County: 1,218 square miles

Resident Population: 400,000

Migrant Health Project Staff:
- 1 Public Health Nurse Supervisor
- 2 Public Health Nurse II's
- 1 Sanitarian
- 1 Clerk-Typist
- 1 Community Health Worker

PRETEST DRAFT - 1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT
For May 1, 1967 through April 30, 1968
Date submitted 5/22/68

BROWARD COUNTY

PART I - GENERAL PROJECT INFORMATION

1. Project Title
Project To Develop A State-Wide Program Of Health Service For Migrant Farm Workers And Their Dependants In Florida.

2. Grant Number (use number shown on approved application)
MG-18E-(68)

3. Name and Address of Applicant Organization
Broward County Health Department
2421 Southwest Sixth Avenue
P. O. Box 1021
Fort Lauderdale, Florida 33302

4. Project Director
Paul W. Hughes, M.D.

5. Population Data - Number of Migrants (workers & dependents) for Broward County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	12076	5608	6468
Under 1 year	510	245	265
1 - 4 years	2004	900	1104
5 - 14 years	5010	2400	2610
15 - 44 years	3348	1518	1830
45 - 64 years	827	360	467
65 and older	377	185	192
2. In-migrants			
Total	4024	1993	2031
Under 1 year	170	80	90
1 - 4 years	668	310	358
5 - 14 years	1670	790	880
15 - 44 years	1116	590	526
45 - 64 years	275	160	115
65 and older	125	63	62

b. Number of migrants by month:

Month	Total	Month	Total
Jan.	16000	Jul.	12000
Feb.	16500	Aug.	12000
Mar.	16000	Sep.	13000
Apr.	15500	Oct.	14000
May	14000	Nov.	15000
June	13000	Dec.	16000

c. Average stay of migrants in county:
Out-migrants: 38 weeks
from Sept. (mo.) through May (mo.)
In-Migrants: 12 weeks
from Sept. (mo.) through May (mo.)

d. Source of information and/or basis of estimates:
See Attachments - Exhibit 1 and 2.

6. Housing accommodations for Broward County:

a. Camps

Maximum Capacity	Number	Occupancy (peak)
Less than 10 persons	1	1
10 - 25 persons	7	96
26 - 50 persons	6	240
51 - 100 persons	4	253
More than 100 persons	4	2200
Total		2790

b. Other housing accommodations

Type	Number	Occupancy (peak)
Farms	MINI	MAL
Other locations	2000	14000

c. Append map showing location of camps, roads, clinics, and other places important to project.

PRETEST DRAFT - 1967

BROWARD COUNTY

Project No. MG-18E-(68)
Date submitted 5/22/68

PART II - MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services: 8/1/67 - 4/30/68

Age	Number of patients			Number of Visits
	Total	Male	Female	
Total	117	74	43	117
Under 1 year	4	2	2	4
1 - 4 years	9	6	3	9
5 - 14 years	4	4	0	4
15 - 44 years	62	34	28	62
45 - 64 years	37	27	10	37
65 and older	1	1	0	1

2. Patients hospitalized: 8/1/67 - 4/30/68

Age	Number of patients			Hosp. Days
	Total	Male	Female	
Total	114	60	54	974
Under 1 year	26	10	16	181
1 - 4 years	6	5	1	49
5 - 14 years	0	0	0	0
15 - 44 years	53	20	33	340
45 - 64 years	27	23	4	375
65 and older	2	2	0	29

3. Patients receiving dental services:

Item	Total	Under 15	15 and Older
a. Number of migrants examined: total	0	0	0
Number of decayed, missing, filled teeth	0	0	0
Average DMF per person	0	0	0
b. Individuals requiring services: total	0	0	0
Cases completed	0	0	0
Cases partially completed	0	0	0
Cases not started	0	0	0
c. Services provided: total	2312	400	1912
Preventive	0	0	0
Corrective	0	0	0
Extraction	2312	400	1912
Other	0	0	0
d. Patient visits: total - (The only dental services rendered at our clinic are - extractions.)	1275	304	971

4. Immunizations provided:

Type	Incomplete series	Completed immunizations - by age					Boosters, revaccinations
		Total	Under 1 year	1 - 4	5 - 14	15 and older	
All types	469	495	75	227	125	0	61
Smallpox	0	25	4	7	4	0	10
Diptheria	124	132	13	45	54	0	20
Pertussis	115	69	13	45	4	0	20
Tetanus	124	132	13	45	54	0	7
Polio	106	114	16	71	23	0	20
Typhoid	0	0	0	0	0	0	4
Measles	0	30	16	14	0	0	0
Other (specify)	0	0	0	0	0	0	0

Pretest Draft
1967
Project No. MG-18E-(68)
Date submitted 5/22/68

5. Medical conditions found by physicians among outpatients, by age of patient

BROWARD COUNTY

ICD Class	Diagnosis or condition	Total	Age of Patient: Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
I	Infective and parasitic dis.	948	19	205	550	134	33	7
	Tuberculosis P.P.D.							
	Venereal disease	50	0	0	0	48	2	0
	Measles	20	0	10	10	0	0	0
	Infestation with worms	584	5	122	446	11	0	0
	Dermatophytosis & other infections of skin	294	14	73	94	75	31	7
	Other	0	0	0	0	0	0	0
II	Neoplasms							
	Malignant	0	0	0	0	0	0	0
	Benign & unspecified	0	0	0	0	0	0	0
III	Allergic, endocrine, metabolic, and nutritional dis.	97	1	2	3	52	39	
	Diabetes	85	0	0	0	48	37	0
	Malnutrition	12	1	2	3	4	2	0
	Other	0	0	0	0	0	0	0
IV	Dis. of blood and blood-forming organs	14	1	0	0	12	0	1
	Anemias	14	1	0	0	12	0	1
	Other	0	0	0	0	0	0	0
V	Mental, psychoneurotic and personality disorders	0	0	0	0	0	0	0
VI	Dis. of nervous system and sense organs	197	20	62	55	47	13	0
	Cerebro-vascular disease (stroke)	6	0	0	0	2	4	0
	Eye diseases	86	14	29	25	17	1	0
	Dis. ear and mastoid process	70	6	30	29	3	2	0
	Other dis. of nervous system Epilepsy	35	0	3	1	25	6	0
VII	Dis. of circulatory system	579			3	281	265	30
	Rheumatic fever	13	0	0	1	5	5	2
	Diseases of the heart	138	0	0	2	71	62	3
	Hypertension & other dis. circulatory system	428	0	0	0	205	198	25
VIII	Dis. of respiratory system	977	173	272	170	229	108	25
	Upper respiratory	847	173	268	156	174	70	6
	Influenza and pneumonia	14	0	0	0	7	7	0
	~~Bronchitis~~ Asthma	114	0	4	14	48	29	19
	Other Emphysema	2	0	0	0	0	2	0

5. Medical conditions found by physicians among outpatients, by age of patient (Cont)

Pretest Draft
1967
Project No. MG-18E-(
Date Submitted - 5/22/68

BROWARD COUNTY

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
IX	Digestive system diseases	551	57	55	48	238	140	23
	Teeth and supporting structures	260	0	0	0	161	88	11
	Gastroenteritis, colitis	291	47	55	48	77	52	12
	Other	0	0	0	0	0	0	0
X	Dis. of genito-urinary system	280			5	209	60	6
	Urinary system diseases	88	0	0	0	46	36	6
	Genital system diseases	192	0	0	5	163	24	0
XI	Deliveries and complications of pregnancy	8	0	0	0	8	0	0
	Complications of pregnancy	7	0	0	0	7	0	0
	Deliveries	0	0	0	0	0	0	0
	Complications of puerperium	1	0	0	0	1	0	0
XII	Skin diseases	59	4	29	26			
	Impetigo	40	0	20	20	0	0	0
	Other: Larva Migrans	19	4	9	6	0	0	0
XIII	Dis. of bones & organs of movement	113	0	1	4	35	64	9
XIV	Congenital malformations	1	0	1	0	0	0	0
XV	Dis. of early infancy	0	0	0	0	0	0	0
XVI	Symptoms, ill-defined cond.	120	3	2	9	76	27	3
XVII	Accidents, poisonings, violence	191	1	23	40	90	37	0
	TOTAL OF CATEGORIES I-XVII	4135	269	652	913	1411	786	104
SUPP	Special conditions, examinations, without sickness:Total							
	Prenatal, postnatal care	0	0	0	0	0	0	0
	Physical examination	0	0	0	0	0	0	0
	Immunizations	0	0	0	0	0	0	0
	Surgical or medical after-care, follow-up	0	0	0	0	0	0	0
	Fitting prosthetic devices							
	Other: Family Planning	100	0	0	2	98	0	0

PRETEST DRAFT - 1967
Project No. MG-18E-(68)
Date submitted 5/22/68

BROWARD COUNTY

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number
a. Visits to homes	1090
b. Total households served	306
c. Visits to schools, day care centers: total	34 14
d. Migrants presenting health record on request (PHS 3652)	12
e. Migrants given health record	100
bl. No. Individuals Served: total	2539

Services provided:	Number
f. Health supervision, counselling, teaching, demonstrating care At back door for service	1090
g. "Sick call" (nursing clinics)	600
h. Referrals for medical or dental care: total	197
Within area: total	195
Number completed	195
Out of area: total	2
Number completed	2
i. Other (specify)	0

2. Sanitation services

Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	22	4	409	78	290	3	2	44
Urban or other locations	NOT AVAILABLE (Estimate - 2000) See Part I: 5D and explanation of Tables 6 A and B.							

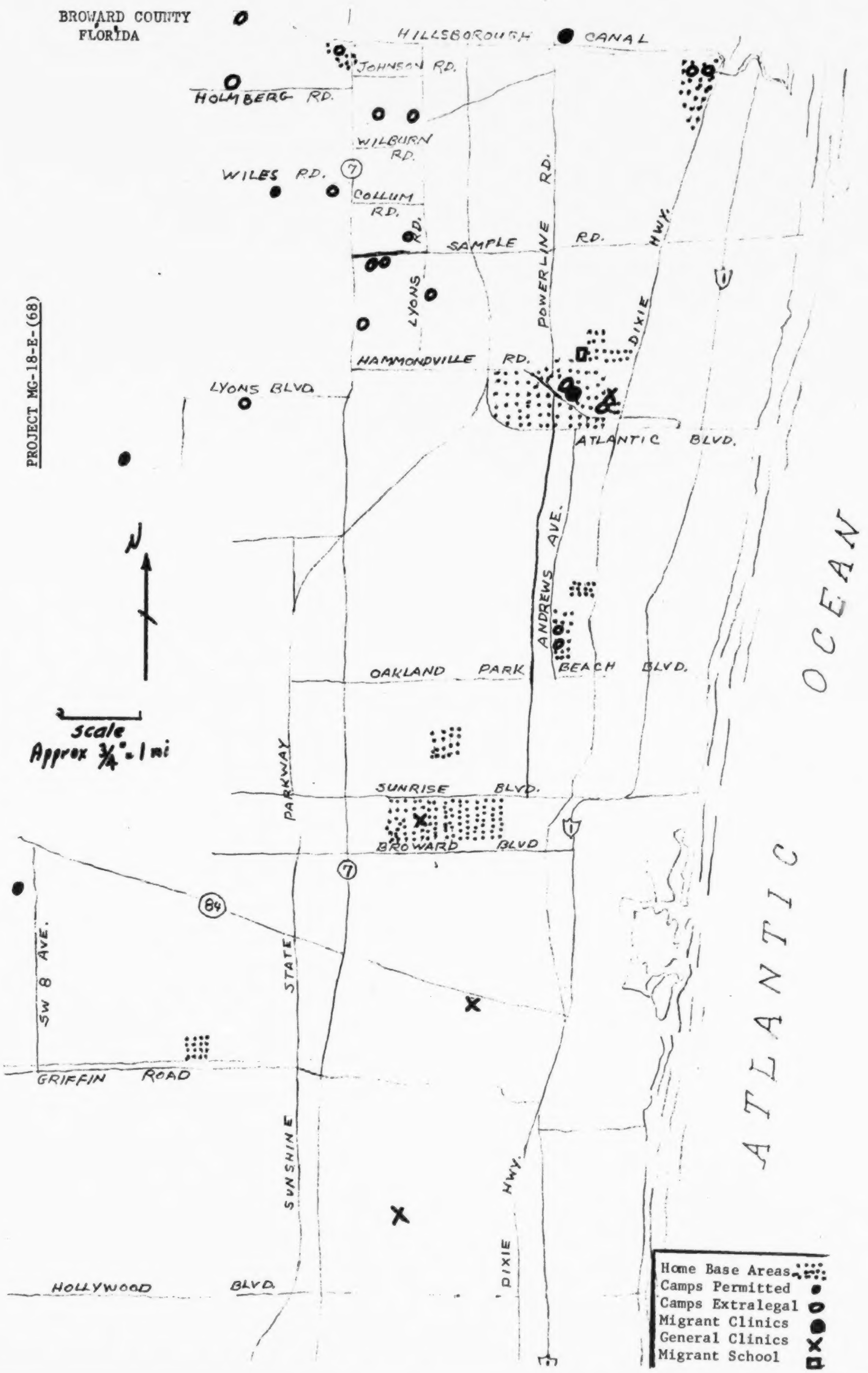
Table B. Inspection of living and working environment of migrants

	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	3	74	6	6
b. Sewage	36	135	67	40
c. Garbage and refuse	66	154	89	75
d. Housing	23	242	166	112
e. Safety	0	10	5	1
f. Food handling	38	52	26	13
g. Insects and rodents	4	7	3	3
h. Recreational facilities	0	0	0	0
Total:	170	674	362	250
Working environment				
a. Water				
b. Toilet facilities				
c. Other				

* Locations - camps or other locations where migrants work or are housed

BROWARD COUNTY
FLORIDA

PROJECT MG-18-E-(68)


HILLSBOROUGH CANAL
JOHNSON RD.
HOLMBERG RD.
WILBURN RD.
WILES RD.
7
COLLUM RD.
LYONS RD.
SAMPLE RD.
POWERLINE RD.
DIXIE HWY.
1
HAMMONDVILLE RD.
LYONS BLVD.
ATLANTIC BLVD.
N
ANDREWS AVE.
OAKLAND PARK BEACH BLVD.
scale
Approx 3/4" = 1 mi
SUNRISE BLVD.
PARKWAY
BROWARD BLVD
1
7
84
SW 8 AVE.
STATE
GRIFFIN ROAD
SUNSHINE
DIXIE HWY.
HOLLYWOOD BLVD.
ATLANTIC OCEAN
Home Base Areas ⁘
Camps Permitted ●
Camps Extralegal ○
Migrant Clinics ●
General Clinics ×
Migrant School □

BROWARD COUNTY

Exhibit I

5-D-1 (Sanitation)

Broward County is home base for many migrants. This poses the problem of identification. Many families will stay in the area all year with one or more members going north during the summer, depending upon local economic conditions. If they can get and keep jobs they stay; if not, they go North. Part of our tourist season workforce go North to work as pickers in the off season, if the money is right. We have the migrant most of the time.

Exhibit II

Explanation of 6-A and B (Sanitation)

Our estimates are based on an in-and-out migrant workforce of 4,000 (full and part time) workers with approximately 12,000 dependents. The Florida Industrial Commission agent lists our area as having approximately 4,000 workers and does not feel that 12,000 is an over exageration of dependents.

The estimates for 6-B are based on one home for each four workers.

PROJECT MG-18E (68)

"COMPARISONS OF SERVICES BY YEAR FOR THE PERIOD 1965 - 1968"

IMMUNIZATIONS	1965	xxxxxxxxxxxxxxxxxxxxxxx 222
	1966	xxxxxxxxxxxx 112
	1967	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 655
	1968	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 964
U.R.I.	1965	xxxxx 79
	1966	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 324
	1967	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 607
	1968	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 864
C.V.D.	1965	xxxx 75
	1966	xxxxxxxxx 106
	1967	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 357
	1968	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 619
SKIN	1965	xxx 42
	1966	xxxxx 86
	1967	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 446
	1968	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 353
G.I.	1965	xxx 41
	1966	xxxxxxxxx 98
	1967	xxxxxxxxxxxxxxxxxxxxxx 216
	1968	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 311
E.E.N.T.	1966	xxxxxxxxxxxx 148
	1967	xxxxxxxxxxxxxxxxx 184
	1968	xxxxxxxxxxxxxx 156
DIABETIC	1967	xxxxx 82
	1968	xxxxx 83

Distribution of Patient-Visits to Migrant Health Center
Pompano Beach, Florida
(May 1, 1967 through April 30, 1968)

CONDITION OR DISEASE	VISITS
U.R.I.	864
C.V.D.	619
Infestation with Worms	584
Skin	353
G.I.	301
Teeth and Supporting Structure	262
Genital System Disease (Gyn.)	192
Accidents	191
E.E.N.T.	156
Disease of the Bones, etc.	122
Symptoms, Ill-Defined	121
Asthma	114
Urinary System Disease	97
Diabetes	83
Venereal Disease	50
Measles	20
Anemias	13
Malnutrition	12
Mental	5
Endocrine, etc.	5
TOTAL	4,164

PATIENT REFERRALS FROM MIGRANT PROJECT TO OTHER AGENCIES

OTHER SOURCE	NUMBER REFERRED
Welfare Department	81
Health Department	76
Hospital	22
Specialist	13
Vocational Rehabilitation	1
Veteran Hospital	2
Florida Crippled Children's Commission	6
Florida Council for the Blind	1
TOTAL	197

PATIENT VISITS TO MIGRANT MEDICAL CLINIC
May, 1967 - April, 1968
(By age and sex)

AGE	MALE	FEMALE	TOTAL
Under 15	686	654	1,340
15 - 44	420	902	1,322
45 & Over	526	459	985
TOTAL	1,632	2,015	3,647

BROWARD COUNTY MIGRANT HEALTH PROJECT
ANNUAL PROGRESS REPORT

May 1, 1967 - April 30, 1968

The 1967-68 season has been a bountiful one for the growers and a most gratifying one for the Migrant Health Project. We observed an increase in the migrant population of some 2,000 workers and dependents. Our services have expanded and we are now able to offer a complete range of medical services through our clinics, as well as an efficient referral system to various hospitals and agencies. The project nurses have actively sought the aid and cooperation of the local welfare agencies resulting in prompt medical care available to all in need.

The center has come to represent to the migrant and his family a place of total involvement, giving services not only in the field of medicine, but assistance with family or social problems as well.

Our clinic census remains heavy, with many patients returning from season to season and new names being added constantly to our rolls.

We finish this season with a real sense of accomplishment but still acutely aware of the work yet to be done.

I. GENERAL INFORMATION:

A. Period covered by narrative report May 1, 1967, through April 30, 1968.

B. The following were our objectives for the previous reporting year:

1. To improve the general health status of the migrant and his family.
2. To motivate the migrant to improve his health and health conditions.
3. Increase the number of field visits by the public health nurse to familiarize the new migrants in the area with our services.
4. Maintain records of program activities and accomplishments that will reveal such items and services that should be expanded.
5. Increase the number of migrant health service referrals made and the number of personal health records given.
6. Increase the amount of information relating to the Migrant Health Project disseminated to the public.

C. The objectives stated in last years annual report remain the foundation upon which we intend to build a comprehensive health program for the migrant agricultural worker and his family.

Our accomplishments in regard to increased number of field visits, patient teaching, clinic services, and migrant referrals still will not allow us to claim success or even lessen the emphasis on these points.

As a result, the following list of objectives for 1968 was compiled as a supplement rather than to indicate change in the policies of the Broward County Migrant Health Project.

1. Promote more community involvement.
2. Improve grower and crewleader cooperation with the Project.
3. Promote health education both in classes at the Migrant Health Center and in the home.
4. Increase casefinding through Venereal Disease and Tuberculosis screening at the beginning of each season.
5. Promote transportation service.
6. Increase staff's knowledge of the cultural backgrounds of the Puerto Rican migrants.
7. To promote attendance of migrant mothers to child spacing clinics.
8. Organize an active Immunization Program.
9. Alert Economic Opportunity Coordinating Group and Community Action Fund agencies of likely prospects in the migrant ranks for education and job placement.

D. Significant changes in the migrant situation from previous year.

1. The migrants themselves -

    a. There has been an increase in the number of 40 - 50 year old, chronically ill or disabled migrant laborers treated in our clinic in the past year.

    Many have come to Florida with the idea of settling in the warm climate. They are followed in the Migrant Clinic until the County Welfare residency requirement of one year has been met and are then transferred to the county clinics for future care. We now see many more patients with hypertension, cardiovascular involvement, diabetes and other disabling conditions which prevent them from meeting the gruelling demands of the migrant way of life.

    b. The migrant work force remains predominantly Negro (59 per cent) and give their place of origin as Florida or Georgia. The Puerto Rican population remains second with 33 per cent, Texas-Mexican with 7 per cent, and Caucasians the minority at approximately one per cent.

    c. Included in "b" above.

    d. The destinations of the Negroes after finishing the season in Florida remains primarily the Carolinas, Virginia, Pennsylvania, and New Jersey. The Puerto Ricans return to New Jersey, New York, Indiana, and Michigan with a small percentage rejoining their families in Puerto Rico.

2. Economic Situation -

   a. The beginning and ending dates this season of November to May remain the same as the previous reporting period. However, one of the largest farms will continue to operate well into June.

   b. Market prices were held high throughout most of the year. It is thought that hurricane damage and salt contamination of the fields in Texas, rendering them unfit for cultivation this season, may have aided this price increase.

   c. Most bean farmers converted to picking machines this year. One farmer continues to use hand pickers for harvest quality. Our biggest hand picked crop is still tomatoes.

   Due to increased acreage under cultivation and the continuing market for quality produce, Broward County's need for large numbers of agricultural workers remains consistent.

3. Comments -

   As of yet, mechanization has made no significant impact in our county. Even though the bean farmers are beginning to use more machines, there is still the demand for hand picking. We know that in order to have a full complement of workers daily, many migrants are needed. Absenteeism is due mainly to alcohol and illness, either acute or chronic. Therefore, our objectives concerning the care offered to the migrant and his family remain the same as the last reporting year, with the addition of the changes previously stated. Transportation arrangements are still difficult. An attempt is being made to set up a "car pool" comprised of volunteers from a local church group. Still in the planning stage is a move to enlist the cooperation of the growers and crewleaders to orient them to our services. The staff nurses will set up appointments during the summer to talk with key people on each farm. At the same time, they will try to impress the fact on the grower that our success will also mean an economic benefit to him, hoping then that he will assist in our programs for elevating the health standards of his workers.

CASE HISTORY - CENTENO

On February 21, 1968, a Puerto Rican woman came into the clinic asking for vitamins for her infant son. We asked if she wanted the doctor to examine the baby and she refused, stating that the baby was "doing O.K." One of the nurses insisted that the baby be weighed and began to remove his outer garments. She noticed immediately that the child was in extremely poor condition and obviously suffering from malnutrition. Upon questioning the mother, it was learned that the child was 1½ months old and his birth weight had been six pounds, seven ounces. His present weight was six pounds, four ounces.

He has been left in the care of an 11-year-old sister every day, while the mother worked in the fields, and was fed only whole milk. The prepared formula with iron that had been furnished by the Migrant Health Clinic was still sitting on the shelf at home, none was used.

The mother was not only ignorant of the baby's poor condition, but showed no concern when we informed her that the baby needed immediate hospitalization. She denied having any source of transportation and an ambulance was finally called by the nurse, after seeking a volunteer for some two hours.

A call was then placed to the Pediatric Resident at the receiving hospital and we were assured of the child's admission.

Later, we learned that the baby was suffering not only from malnutrition, but Shigella, Salmonella and E. Coli diarrhea and had a congenital abnormality of the urinary tract as well. Because of the baby's extremely poor home situation, the doctor kept him in the hospital 24 days, until he had made a full recovery.

Child Welfare has since been called in on the case and with the joint efforts of the project nurse and the social worker, progress is being made in educating the mother to her responsibilities to her family.

II. General Description of Project Operations During Year -

A. All clinics are held at the Migrant Clinic located in the Pompano Farm Labor Camp, Pompano Beach, Florida.

1. May 1, 1967 - October 31, 1967 - Schedule of Clinics

Monday:

Medical Clinic	6:00 - 9:00 p.m.
Dental Clinic	6:00 - 9:00 p.m.

Wednesday:

Medical Clinic	2:00 - 4:00 p.m.

November 1, 1967 - April 30, 1968 - Schedule of Clinics

Monday:

Medical Clinic	6:00 - 9:00 p.m.
Dental Clinic	6:00 - 9:00 p.m.

Tuesday:

Medical Clinic	2:00 - 4:00 p.m.

Wednesday:

Medical Clinic	6:00 - 9:00 p.m.
Dental Clinic	6:00 - 9:00 p.m.

Thursday:

Family Planning Clinic 6:00 - 9:00 p.m.

There were 125 medical clinic sessions and 3,647 patient clinic visits made during this reporting period.

There were 68 dental clinic sessions and 1,275 patient clinic visits. The family planning clinic began in December, 1967. There were 16 clinic sessions and 100 patient clinic visits during this period.

2. The Migrant Project nurses are responsible for opening all maternity and well-baby records. However, the physical examinations are performed in the Pompano Health Department clinic. The field work is then assigned to the Migrant Project nurse.

3. Health education has been carried out on an individual basis during home visits. Instructions appear to be more readily accepted by the patients when given in their own surroundings and by using the implements and facilities at hand.

4. An excellent rapport has been established with the local medical facilities and referrals have been very successful. Our largest hospital, Broward General, now accepts all referrals even though we have no funds to cover clinic care. Our relationship with this hospital was cemented by a visit paid to the Migrant Health Center by two social workers and the hospital Pediatric resident. Some controversy had arisen as to why the children were at the point of death before being brought to the Emergency Room for treatment. After a complete tour of several of our largest camps, the doctor was astounded as he viewed the poor living conditions of the migrant families. The Pediatric resident's original intention to make a critical appraisal of the Migrant nurses, turned to a feeling of disbelief at the living conditions of some of the children he had cared for in the hospital. In parting, he remarked that we were facing an almost insurmountable obstacle in our work and offered to cooperate fully in any way he could. The social workers were grateful for the opportunity to view the migrant's home situation and offered their assistance in obtaining optimum medical care through the hospital clinics. We now receive complete reports on all inpatients immediately.

5. The staff at the Migrant Health Center consists of three nurses and a clerk. Working part-time are three doctors, two dentists, a dental assistant and a Neighborhood Youth Corp worker who assists in the Dental Clinic. Funds have recently been allocated for a Community Health Worker, but the position has not, as yet, been filled.

6. Important advances have taken place in the past year in the realm of medical care offered to the migrants. Our referrals to the specialty clinics at Broward General Hospital are acted upon quickly and completely. A contract was drawn up with a local laboratory to handle any tests requested by the clinicians. Prescriptions given out in the emergency room of contract hospitals can now be taken to a drug store and filled immediately. The drug store was chosen for its close

proximity to the largest concentration of migrant workers. This pharmacist has an active association with other welfare agencies in the county. The dental services offered by the Migrant Health Center remain limited to extractions because of lack of time, equipment, and space. Fortunately the migrant children, with proof of identification, are eligible for complete dental care through the Pompano Health Department Dental Clinic.

7. The plans to raze the old Pompano Farm Labor Camp and rebuild with modern housing will bring with it a larger and more fully equipped Migrant Health Center. Changes can then be brought about to expand our dental services to include complete examinations, x-ray and restorations. A larger building will also enable the Project nurses to hold classes and demonstrations. The staff must then be increased if these changes are to come about.

B. Hospital Care -

Arrangements for inpatient care for migrant farm workers has, in the past, been difficult and many times discouraging. With no funds available for care, the hospitals were reluctant to admit service patients unless their condition was extremely serious. With the allocation of funds to the two contract hospitals for inservice and emergency room care, the situation has eased considerably. Non-emergency cases needing intensive medical care or surgery are now routed through Broward General Hospital specialty clinics, where a preliminary workup is done and then the patient is admitted for treatment. The social workers in both contract hospitals have been most cooperative in sending detailed summaries to the Migrant Clinic on all our patients immediately after discharge, thus providing continuity of care.

It is the duty of the Project nurses to determine the eligibility for payment of these services through the Migrant Health Project. Verification of the inpatient's migrant status poses no problem because of the excellent working relationship between the Migrant Health Project staff and the hospital social workers. We are notified immediately of admissions and a joint effort is then made to obtain all necessary information. In some cases, the eligibility is questionable and a hospital visit by a nurse to ascertain the accurate migrant status will avoid an error in payment.

Emergency room verification is often difficult, however. The patients are questioned by clerical employees rather than trained social workers and addresses are often incorrect or inadequate. As a result, many nursing hours are wasted in a fruitless attempt to locate a patient for verification. With the addition of the community health worker to our staff, we hope to assign these visits to this worker.

C. Other Health Care Activities include:

1. Family Planning Clinics, nursing service to an elementary school with enrollment of 700 students, nursing service to a day care center, immunizations provided, along with individual health teaching.

2. All nursing personnel are involved in all activities at the Migrant Health Center.

3. The major change since the previous year has been the addition of the family planning clinic at the Migrant Health Center. Previous to this year, our patients had to go either to Ft. Lauderdale Health Department or the Pompano Health Department. We hope to increase the number of patients attending our Family Planning Clinic. Economic Opportunity Coordinating Group has recently put two of their workers in the field to encourage women to attend a family planning clinic. One worker connected with the E.O.C.G. is working in the Pompano Labor Camp alone, with the same objective in mind. These workers can follow-up on family planning clinic broken appointments and post-partum patients. We are planning to expand and organize health education aimed at groups as well as on a one-to-one basis to motivate the migrant and stimulate an exchange of ideas among the migrants themselves using group dynamics.

D. The nursing personnel have had very little contact with the growers. The sanitarian on the project, however, is in constant contact with either the grower or his manager. We have an excellent rapport with the welfare agencies, and this insures maximum medical care to the indigent and migrant. Locally, the Migrant Health Project is under the direct supervision of the Broward County Health Department services. Our patients are seen in health department maternity, baby, tuberculosis, and venereal disease clinics, as well as the general medical clinics held at the migrant clinic site.

Day care centers housing migrant children are visited frequently by the Project nurses. All children are given their immunizations, skin testing for T.B., and worm treatment when needed.

The farm labor representative is used on a consultive basis regarding the estimated number of migrants, names of crew leaders, farm forement, locality of concentrations of migrants, and the employment situation.

For a part of the season we had a cooperative Vista worker in our area. Her work involved contact with the migrants on two farms. She kept the nurses fully informed of health problems in these areas. She also took many of our patients to clinics when transportation was necessary.

We have had very little cooperation with the crewleaders. There are many of them in the area and their main objective is to get the workers into the fields.

E. The community groups are willing to donate used clothing, layettes and baby foods but refuse any active participation in other areas of the project.

F. Consultation and Assistance Needed:

1. Plan to visit other project areas.

2. Familiarize growers with our services and attempt to enlist their aid.

3. Attempt to engage crewleaders in furnishing transportation and phone us regarding health problems among their crews.

4. Attempts at enlisting the cooperation of the local E.O.C.G. had been discouraging, but we are now receiving some assistance. We will continue

to seek their aid in planning and conducting projects.

G. All new nursing personnel are oriented to the health department and to the community resources by the county health department educational supervisor. Following this orientation, the nurse is given an orientation to Migrant Health Project activities by the project supervisor. This specific orientation is adequate, but involves a great deal of time due to the diversity of the nurses functions as required by the project.

III. General Appraisal of Year's Achievements:

A. Our evaluation of health care activities will be detailed in the nursing segment of the report.

B. The biggest deficit or weakness in our program is a shortage of personnel. Nurses frequently have to function as clerks, messengers, janitors, dental assistants, and in other non-nursing activities.

C. If we are ever to broaden our scope of services, an increase in professional and auxiliary help is essential.

BROWARD COUNTY MIGRANT HEALTH PROJECT

NURSING

I. General Description of Nursing Services -

A. Staff Involved:

1. Professional:

One Public Health Nurse Supervisor
Two Public Health Nurses

Family Planning Clinic:

One Public Health Nurse from the Maternal and Infant Care Project (MIC) - four hours per week
One R.N. (fee nurse) - four hours per week.

2. Other:

a. One paid full-time clerk
b. One Diversified Clerical Trainee - twelve hours per week - paid from general budget of the health department.
c. One MIC clerk working only in Family Planning Clinic - 4 hours.
d. One paid dental assistant - four to eight hours per week.
e. One Neighborhood Youth Corp worker - four to eight hours per week.

B. Specific Objectives and Duties of the Nursing Staff:

1. To promote and assist with a complete range of medical services.

2. To assist as a clinic nurse in Medical and Dental clinics.

3. A referral source not only medically, but with social and economic problems of migrants.

4. Knowledge of all the available resources in the community and eligibility requirements of agencies.

5. The nurse must be alert to the existing problems of the patient.

6. Ordering all drugs and supplies necessary for clinic operation.

7. Compiling statistics relevant to clinic attendance, field visits, those required by the Broward County Health Department, State Board of Health, and the annual report.

8. Verification of all patients receiving in-service and emergency room care at the two contract hospitals.

9. Liaison between migrants and the community.

10. To offer consultive services to the migrant elementary school and day care center.

11. Specific duties in family planning clinics.

    a. Make out all medical records pertaining to past and present medical history.
    b. All laboratory work necessary.
    c. Assist the doctor in the performance of his duties.
    d. Prior to the doctor's examination, conduct a class explaining the various methods used in Family Planning in order that the patient may decide what method she prefers.
    e. Interview patient after she has been seen by the doctor and explain her responsibilities regarding the method chosen.

12. The duties of the full-time clerk are almost too numerous to mention. She is one of our most valued employees and perform duties above and beyond those of most clerks.

    a. Opens and closes all cases within the health department confines.
    b. Makes out all laboratory slips, records same on the proper records and files.
    c. Types all correspondence.
    d. Makes out all medical and dental records on new patients attending the migrant clinic and partially screens patients regarding their migrant status.
    e. Makes out all time vouchers for doctors and dentists.
    f. Responsible for Code Tally Report.
    g. Mileage forms.
    h. Answers all in-coming phone calls, many times giving the caller the desired information; thereby relieving the nurse so that she may continue with her duties.

    We have recently employed a high school senior under the Diversified Cooperative Training program. She relieves the clerk of such duties as filing records, making out laboratory slips, limited amount of typing, operates the sterilizer. Prints material used on the bulletin boards and many minor duties; thus allowing the clerk to perform the more important functions of her job.

13. The clerk in the Family Planning Clinic was chosen because she speaks Spanish fluently. She works four hours a week from the MIC Project. She assists the nurse in making out the medical history and again in explaining the method of Family Planning chosen by the patient. She is also responsible for pulling the patients' records and making out lab slips so that they will be attached to the record for the doctor's use.

14. Dental Assistant: Due to the fact that only extractions are done in our dental clinic, it is most important that the dentist have a competent assistant. Actually much of our work is oral surgery and the assistant must remain with the patient while the work is being done. She must know when and where to aspirate and assist when suturing is necessary.

    For the past year we have had a Neighborhood Youth Corp employee working in the dental clinic. She has been trained to set up the dental clinic prior to the dentists' arrival. She washes and sterilizes all instruments between patients, calls the patients to the dentists' arrival. She washes and sterilizes all instruments between patients, calls the patients to the dentists' office and fills out all the dental records; recording the teeth extracted, sutures or suture removal and any medication given.

C. Relationship with and involvement of migrants, growers, and other Project staff members:

1. To establish a relationship with the migrant, the Project staff must be familiar with their cultural background.

2. Working relationships have improved this year between the Migrant Health Project and the two contract hospitals.

3. Nurses are an advisory and contact point between the migrant and community.

4. Nurses enlist the aid of various groups for transportation, drug companies for teaching materials and samples, various agencies for help in health and welfare problems; as well as participating in educating the community to the migrants needs and way of life.

5. A team approach of the Migrant Health Project staff and other health department personnel is needed to solve many of the migrant problems.

6. Relationship with the growers has been limited.

D. Consultation received from outside Project - type and source:

1. Referral to private doctors for consultation.

2. Referrals to special medical clinics at Broward General Hospital.

3. County and State Welfare agencies.

4. Vocational Rehabilitation.

5. Social Security.

6. Veteran's Hospital.

7. Florida Council for the Blind.

8. Florida Crippled Children's Commission.

9. Community Action Fund.

10. Economic Opportunity Coordinating Group.

E. Continued consultation from the above listed groups is a necessity.

II. Services Provided to Migrants:

A. The Migrant Health Center is the source from which originates the many facets of care to the migrant agricultural workers.

1. The nursing services provided during the clinics are:

    a. Interviewing the patients prior to the doctors examination.
    b. Assisting the doctor.
    c. Urinalysis (labstix used).
    d. Draw blood samples for Dextrostix and hematocrits as well as any tests ordered by the physician to be sent to an outside laboratory.
    e. Weigh all patients and take blood pressure, temperature, pulse and respiration as indicated.
    f. Cleanse wounds prior to treatment by the doctor and change dressings as indicated.
    g. Patient teaching and distribution of appropriate literature.

During the time when the clinic is not in session, many patients come to the door with problems ranging from medical emergencies to domestic quarrels. We have encouraged this practice as it has deepened the migrants' confidence in our program and the staff.

Our referral work involves not only the health department clinics, but the two contract hospitals, the Veteran's Hospital in Miami, private physicians, and various welfare agencies as well.

As a result of our reaching out into the community through lectures and meetings, we have received offers of help from interested citizens. These offers are still few in number but plans are being made which we hope will result in a well-knit and functioning organization of volunteer help by the beginning of next season.

2. Services provided Outside the Clinics:

The camp work basically includes supervision of patients; i.e., infants, prenatal and post-partum patients, tuberculosis, V.D., mental health patients, and referrals to community agencies as needed.

While in the migrant home, education of the family may include such areas as nutrition, dental hygiene, personal hygiene, formula preparation and comprehensive baby care. In addition, prenatal care and family planning.

The project nurse becomes involved within the family circle, listens to their problems and may endeavor to advise in an objective and impartial manner. Thus we have a nurse playing the roll of friend, confidante, teacher, and counselor on economic and social problems, as well as carrying out her medical duties.

Recently a Halfway House was set up directly across the street from the Migrant Health Center to house ambulatory migrants who were discharged from the hospital but had not achieved a full recovery. A situation has now evolved in which migrants are admitted to Halfway House who are critically ill or suffering from poor hygiene and malnutrition with no previous address other than a field or abandoned car. Many times these patients will stay just long enough to get cleaned up, a good meal and a night's rest, then strike out on their own. Frequently the medical dispostion of some of the cases results in their admittance to a hospital after a Project nurse has made a visit to check on the patient's condition. All Halfway House occupants are eligible for services through our clinic with the responsibility for follow-up care again resting on the Project nurses.

Last year an elementary school, with an enrollment of approximately 750, was opened in Pompano for the children of migrants and agricultural workers. It was staffed with teachers who had received special trainin the problems of the socially deprived child. They divided the students into learning levels rather than grades which enables them to place a child at a level dictated by accomplishment or ability rather than age.

It was because of the school's sincere interest in the total well-being of their students that a broad health program was initiated. Some 35 visits were made to the school by the Project nurse for routine matters and seven special programs were held. These included audio-visual programs on eye testing, dental hygiene, and menstruation and growth and development. Other special projects completed during the year were: tuberculin skin testing (PPD), treatment for intestinal parasites, dental screening with subsequent referrals done by the Pompano Health Department dentist and the dental hygienist from the Florida State Board of Health. A lecture to a select group of students on syphillis and gonorrhea was given by a Health Department V.D. Investigator.

The children of the Child Care Centers were also given worm treatment and tuberculin skin tests (PPD) were done. Immunizations including Smallpox and Measles will be completed by June of 1968. The administrators of the centers have worked closely with the Project staff in case of child neglect by taking them in to assure proper care, at least while the parents worked. The nurses have made themselves available to local organizations for meetings and lectures with the idea of enlarging the communities concept of the migrant way of life. As a result, the Migrant Health Center received approximately 300 Christmas gifts last year which were distributed to needy migrant families. We were also instrumental in obtaining Christmas baskets and gifts through the Welfare Clearing Bureau in Broward County from some 15 families in the various camps. Another project which will be in full swing about July, 1968, is a six-hour course covering the Expectant Mother. We are currently reviewing films, collecting necessary equipment for demonstrations, and receiving layettes made by women in the community. We have also received donations of formula from a pharmaceutical firm and jars of baby food from local church groups. Through films, demonstrations, and instructions, we plan to cover: Human growth and development, human reproduction, nutrition, dental care, personal hygiene, prenatal care, labor and delivery, post-partum care and child spacing. For the newborn we will cover bathing and feeding, formula preparation and growth and development. At the completion of the course, each mother will receive a complete layette, formula, baby bottles and a starter set of baby foods, vitamins and a baby spoon.

B. Problems Still Unsolved:

1. Transportation: We intend to enlist the aid of volunteer women in the community to relieve this still critical situation.

2. Language Barrier: None of the migrant staff can speak Spanish fluently and the effects of teaching on the Puerto Rican population is many times questionable. The nurses often must seek out an interpreter-translator (usually a Puerto Rican child who has learned English in school) for field visits and it is sometimes difficult to make the interpreter understand the instructions before passing them on to the patient. Beginning in June, the Project nurses will be taking Spanish lessons from a Texas-Mexican migrant who has recently been employed by the E.O.C.G.

3. Broken Appointments: Lack of transportation or a lack of initiative on the part of the patient often results in a Project nurse making several home visits to a patient before they are finally seen in the clinic. We have discovered that if transportation can be arranged beforehand, the patient is more likely to understand the importance of regular clinic attendance.

4. Educational Material: The pamphlets and papers we are distributing at present are excellent in content but are often difficult to understand by the migrant. Most of our patients are either illiterate or semi-literate and simply cannot comprehend the material that is covered in the booklets that are given to this office by the pharmaceutical companies, baby food and formula manufacturers, etc. We are now working on single sheet material which will be written in large print and which is simple in language that the migrant can easily understand.

   We have recently reviewed some new pamphlets which were composed by The Florida State Board of Health's Office of Nutrition solely for distribution to the poorly educated population. The literature was easy to read and illustrated with color pictures the foods commonly used in the migrant home.

C. Out-of-State referrals are sent on patients who are chronically ill and on medication. This includes tuberculosis, maternity, family planning and immunization patients. In addition, anyone needing special follow-up after discharge from the hospital, or others where pertinent information is necessary to improve the health of the migrant have referrals sent.

The most common reason for a referral not being completed is an incomplete or inaccurate address. We have little difficulty in locating migrants who live in the camps but more and more are moving out into the community and a street address or the name of the patient's crewleader is essential.

The patient's nickname would also be of assistance if he is not sure of his exact desitnation at the time of departure. Many times a worker will be well known in the migrant community by a nickname but no one is able to identify him by the name listed on his Social Security card - "Little Tramp," "Fat Willie," and "Sixty Minute-Man," were easily located once we had the name clue. Three visits were made to one camp in search of a patient named Degrafenreid Lattimore, only to discover he had been living there all the time under the alias of "Mack Day."

The Puerto Rican migrant also poses a problem in regard to identification. He quite often will give a last name which is completely different from that stated on his Social Security card. This has resulted in duplication of records in the clinic and often an incomplete referral.

We are all aware that changes in the Migrant Referral are needed and time and study has been spent in regard to the problem. We were disappointed when a referral form was not decided upon for use this season. Until changes are made we will no doubt receive and send incomplete referrals. Some areas are using a roster of the farms and camps and we plan to implement this practice in our program.

CASE STUDY

A 44-year-old man who had been seen in the migrant clinic regularly last season for diabetes, came to our door on January 2, 1968, asking for help. He presented the following symptoms: Blood pressure - 230/124, blood sugar within normal limits, extreme weakness of the right side of the body, slurred speech, and edema of the left leg and right hand. He stated that the right-sided weakness had appeared suddenly two days previously but he was forced to wait until he could get someone to bring him into the clinic. The patient was referred to the emergency room of one of our contract hospitals where he was examined and sent home with instructions to take his pulse regularly and return to the emergency room if the pulse could not be detected. A phone call to the emergency room physican confirmed the patient's story and also revealed that he was told to go to Broward General Hospital for further evaluation. The patient was taught by the Project nurse how to take his pulse and adhesive tape was placed on his wrist to border the area. Close observation of the patient in the home with daily visits by the public health nurse revealed that the patient's condition remained unchanged until his appointment at surgical clinic the following week. From the clinic he was immediately hospitalized with the diagnosis of CVA and transcerebral ischemia. The patient has made slow but steady progress since his discharge from the hospital. Full range of motion exercises were demonstrated by the Project nurse to the family, along with instructions on assisting the patient until he could again care for himself. The diabetes is controlled for the present and arrangements were made for the patient, until he could again care for himself, to receive Social Security benefits since he is not eligible for county or state assistance.

BROWARD COUNTY MIGRANT HEALTH PROJECT
ANNUAL PROGRESS REPORT
SANITATION

I. General Description of Sanitation Service

A. Staff

Staff	Effort
One Sanitarian	100%
One Sanitarian Supervisor I	25%
One Sanitarian Director II	9%
One Sanitary Engineer	Consultant

During the past year, child care centers were taken over by a specialist.

B. Specific Objectives

1. Upgrading camp facilities and their use.

2. Upgrading migrant communities and their public facilities.

3. Investigating animal bites - rabies control.

4. An educational program stressing the importance of good sanitary practices.

Specific Duties

1. Responsible for the routine environmental health program in areas of Broward County, Florida, which include migrant labor camps, housing of migratory laborers which do not consititute labor camps by definition, and the areas in which these people not only live, but also patronize. This work is to be performed with limited supervision from a District Sanitation Supervisor (Sanitarian III) and the Migrant Health Program Director (M.D.). These routine sanitation services would entail inspection and permitting of labor camps; inspection of schools; child care centers, food service and food outlet establishments, water supplies, liquid and solid waste disposal; and investigation of complaints and reported animal bites.

2. Work in cooperation with nurses to plan and execute educational programs. Talks and films are utilized in stressing the importance of good sanitary practices.

C. Work to be Done and Proportion of Work Accomplished

Emphasis has been centered on elimination of shack-type living. For a conservative sanitation program to be functional, it is necessary to have:

1. A sound structure that keeps out the wind and rain with proper ventilation and lighting, air space, and floor space.

2. A "sanitary" place to expel human waste.

3. A place to wash ones body - hot and cold water.

4. A place to wash dishes, pots, pans, clothes, etc. and the premises - hot and cold water.

The above facilities should be functional - built to take transit abuse.

With the rebuilding of the Pompano Labor Camp an anticipated reality, our progress in this area will receive a large boost. The housing authority has rebuilding scheduled for June, 1968. This will eliminate 150 buildings or 300 units with subminimal facilities which is the largest we have and replace the 150 buildings with 100 buildings or 400-plus units meeting the four basic requirements listed above.

This year was the final one for shacks at two camps and the last for two-thirds of the shacks at another.

Pompano Beach and Deerfield Beach are the major migrant areas. Each of these communities has extensive condemnation programs aimed at removing shack-type living. Pompano Beach's Fire Department cooperates with owners in supervised burning of many of these condemned shacks or houses. Both of these communities run constant clean-up campaigns in their migrant areas. The county has condemnation powers, but as yet has not used them. It is hoped that in the future more of their help can be acquired.

Broward County is the home base for many migrants. This poses the problem of identification. Many families will stay in the area all year with one or more members going north during the summer. Therefore, much of our indigent population is migrant. The major effort in these areas has been in garbage and trash control coordinated with an effort to up-grade public facilities as grocery stores, bars, restaurants, schools, etc. Due to the vastness of this area and the detail involved, only the surface has been scratched.

D. Relationships Established with Migrants

The following various aspects of health were discussed with camp personnel:

1. How the fly transmits disease - garbage control.

2. Birth control measures.

3. Water contamination problems.

4. General housekeeping for health (hang clothes, throw things out).

5. Where showers are available - attempts to get people to use them.

With the Farmer:

1. Stress the need for a basic shelter, toilet, body washing facility,

and dishwashing facility.

2. Run the camp rather than let it run itself; this way some problems are avoided.

3. Make demands on workers in terms of keeping their camp home clean.

Other Groups:

1. As a coordinating and public relations effort, the film "The Season People" was shown to those not familiar with the migrant, thus giving them some background as to the magnitude of the migrant problem. Slides were also shown on what is being attempted by the health department.

Working relationships were established with the following agencies:

Florida Hotel and Restaurant Commission: A dual agency attack on garbage, trash, and building conditions in licensed areas. Two agencies are more effective in problem areas.

Housing Authority of the City of Pompano Beach: Anticipated rebuilding of the whole camp with Farmers Home Administration funds. Construction scheduled to start in June.

Building Departments of Deerfield Beach, Pompano Beach, and Broward County: Cooperative effort to remove shack type living and prevent the creation of more problems.

County Solicitors: Legal action to gain compliance with House Bill 269 and Chapter 170C-32 of the Florida State Board of Health Sanitary Code relating to camps: legal action relating to sanitary nuisances, Chapter 386.041, Florida Statutes.

Portable toilet operators: More farmers are using these units as time savers in the field. The problem of excess debris in these units arises occasionally.

Community Action Fund - Community Action Program: Attempt to coordinate efforts.

Broward County Migrant Council: Attempt to steer efforts in the right direction.

Church Groups: Attempt to familiarize these groups with the magnitude and inter-relationship of problems so that "do good" efforts actually achieve their goal.

E. Consultation Obtained from Outside the Project - type and source:

1. Florida Association District 7 Meetings

   a. South Florida Flood Control System
   b. Swimming pool regulations

2. State Board of Health Sanitation In-service Training - three months.

   Workings of the State Board of Health and appropriate sanitation associated fields with visits to Dade, St. Lucie, and Brevard county programs.

3. Staff meetings.

   a. Rabies control.
   b. Miami Laboratory operations.
   c. County Solicitor operations.
   d. Rat control.

4. Lee County Migrant Health Program for local ideas.

5. Collier County Migrant Health Program for local ideas.

6. Miami Plumbing Association Cross Connections.

7. East Coast Migrant Health Conference. Amalgamation of Federal and State ideas.

8. Sanitation Engineering - water and sewage.

II. General Description and Conditions of Housing Accommodations for Migrants.

A. Broward County being the home base for many migrants is a constant factor in our housing accommodations. As we have migrants for a longer period, and their dependents most of the time, this compounds our problem. Migrants seem to seek out the more dilapidated, unorganized areas to live in due to their unstable wages, etc. Our efforts have been to eliminate the shack-type living. Large apartments are a constant garbage problem - cooperation between owner, maintenance, and tenants is essential. Smaller units are better and are the current trend. Individual homes are ideal - properly installed.

B. Analysis of Table A

1. In the evaluation of camps, authority was used under House Bill 269, Chapter 59-476 of the Florida Statutes and inspections using the Sanitary Code, Chapter 170C-32, of the Rules of the State Board of Health for guidelines.

2. An effort was made to keep the number of locations accurate. This means that had a location been previously visited for housing, it was not recoded in the location column when visited for its water, etc. (170 could be on the low rather than high side, 200 or 250 seems more logical.)

3. The total inspection figure of 242 in 23 housing locations denotes the emphasis on camp locations. An average would be ten per camp for an eight month work period. Camp housing has number one priority of work emphasis.

4. The total inspection figure of 154 at 66 locations denotes the effort made to establish garbage control in some of our migrant indigent areas. Seventy-five corrections out of 89 defects shows some improvement.

One hundred sixty-six defects and 112 corrections in the housing area are a bit nebulous. One defect can range from a broken jaulosy to eliminating a building. It is felt that these figures are extremely low, possibly ten times too low.

5. Field sanitation has not received much effort. It has been noted that most crews are getting their water from a city system and ice from an approved manufacturer. Also, some farmers have started using portable chemical toilets in some fields and at grading belts. It has been found that these toilets are time savers as well as a more sanitary means of human feces control. (The production time lost looking for a place to expel human waste is a good selling point.)

6. While the sanitarian was at the three months in-service training program in Jacksonville, the area sanitarian supervisor made 36 garbage and refuse investigations, 19 sewage investigations, 11 camp visits, 7 food handling inspections, and 4 rat and insect investigation.

7. Water and sewage in the county areas not on sewage go hand in hand. Due to the average quality of well water, toilets gum up with sediment and become stained. Maintenance is at a maximum, yet the financial factor for improved water systems is a deterent. Damage and maintenance in this area cause much aggravation. Portable chemical toilets used in some instances eliminate much of the usual mess and help to keep the rest of the water facilities in a better sanitary condition. Taking the feces out of the shower room helps.

8. Garbage and refuse control in camps is better than it has ever been, but still needs policing. In the county migrant communities it is an area of major concern. Much time is spent trying to improve this problem area.

9. Food handling practices in the public facilities have improved with more inspection of facilities.

10. Most rodent control is done on a mass scale during the summer months by farmers. Insect control is handled by Broward County Mosquito Control.

11. Some camps are starting to add recreation facilities and garbage control is improving.

III. Field sanitation has not received much effort. It has been noted that most crews are getting their water from a city system and ice from an approved manufacturer. Also, some farmers have started using portable chemical toilets in some fields and at grading belts. It has been found that these toilets are time savers as well as a more sanitary means of human feces control.

IV. Efforts in Health Education.

A. In our home base area the major work is on garbage control. "The Housefly" film was shown to several groups followed by a presentation on local area disposal systems. In conjunction, a spot legal notice program aimed at the worst offenders was instituted with follow-up subpoenas from the County Solicitor. The enforcement approach seems to be the most effective. You can tell people until you are blue in the fact to put garbage in cans and haul it to the incinerator; the only way it is effective is to make them believers with a legal maneuver. This garbage control has been overlooked or given the "look the other way" treatment for years and to bring about changes in indigent areas is a monumental task. Garbage and trash are things anyone can see. By removing the garbage and trash, a part of the filth is removed along with some of the sickness which contributes to poverty and indigency. It is easy to talk about this problem and it is very evident in most migrant communities. To do something about it is something else. Most of the time, it involves years of debris and takes dozers, trucks, payloaders, graders, etc., time and follow-up. Success in this area is a must.

B. In working with community groups "The Season People" film coupled with a film slide program on local attempts by the health department is used to to try to keep group direction headed the same way. "The Season People" is a film all migrants and health department staffs should be familiar with.

V. General Appraisal of Sanitation Program.

A. Our camp four point structure objective outlined in I-C becomes more of a reality with the projected summer rebuilding of the Pompano Labor Camp. With this government rebuilding, outlying camp problems will hopefully fall in line or cease to exist. We anticipate many problems arising from moving people from three hundred units with minimal plumbing to two bedroom apartments with flush toilets, lavatories, bath facilities, and kitchen sinks.

B. Our objective of garbage and trash control in migrant home base areas, due to its magnitude and time consuming aspect, seems out of reach at this time. Closer cooperation with other city, county, and state agencies may help.

VI. Plans for the Future

A. Number one priority will still be given to the elimination of shack-type living. Broward is proof that if you remove the shack, better structures will evolve.

B. Continued effort will be focused on public facilities used by migrants.

The new migrant school is an excellent example of something poor migrants can be proud of. The more restaurants, bars, etc. that are brought up to this "proud of," "clean," "sanitary" state, the closer we are to having the migrant be a part of the community.

C. Garbage, trash, and filth elimination projects will be continued, and hopefully expanded.

D. Cooperative involvement with E.O.C.G. programs will hopefully expand.

E. There seems to be a movement to change from a Migrant to Comprehensive Health Program in the near future. It is felt that our program is achieving maximum success with minimum staff and financing. An expansion of the present program would be more beneficial than a new program.

F. It is still hoped that the reporting kit will be brought closer in line with the state coding system and available statistics. The problems we have with the annual report are as real as the migrant's problems with life.

COLLIER COUNTY HEALTH DEPARTMENT

Charles F. Bradley, M. D., Director

Area of County:	2,032 square miles
Resident Population:	22,000
Migrant Health Project Staff:	3 Public Health Nurses 1 Senior Sanitarian 1 Sanitarian 1 Motor Vehicle Operator 1 Clinic Aide 1 Clerk-Typist

HEW-PHS
Wash., D.C.

PRETEST DRAFT
1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT

For May 1, 1967 through April 30, 1968
Date submitted May 14, 1968

COLLIER COUNTY

PART I GENERAL PROJECT INFORMATION

1. Project Title
A project to develop a Statewide Program of Health Services for Migrant Farm Workers and their Dependents in Florida

2. Grant Number (use number shown on approved application)
MG-18E (68)

3. Name and Address of Applicant Organization
Collier County Health Department
County Government Center
P. O. Box 477
Naples, Florida 33940

4. Project Director
Charles F. Bradley, M.D.

5. Population Data - Number of Migrants (workers and dependents) for Collier County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	8100	4050	4050
Under 1 year	200	100	100
1 - 4 years	1000	500	500
5 - 14 years	1600	800	800
15 - 44 years	2600	1300	1300
45 - 64 years	1000	500	500
65 and older	200	100	100
2. In-migrants			
Total	8100	4050	4050
Under 1 year	200	100	100
1 - 4 years	1000	500	500
5 - 14 years	1600	800	800
15 - 44 years	2600	1300	1300
45 - 64 years	1000	500	500
65 and older	200	100	100

b. Number of migrants by month:

Month	Total	Month	Total
Jan	22,000	Jul	6,000
Feb	22,000	Aug	10,000
Mar	20,000	Sep	14,000
Apr	18,000	Oct	16,000
May	16,926	Nov	18,000
Jun	6,000	Dec	22,000

c. Average stay of migrants in county:
Out-migrants: 38 weeks
from Sept. (mo.) through May (mo.)
In-migrants: 30 weeks
from Oct. (mo.) through May (mo.)

d. Source of information and/or basis of estimates:
SEE EXHIBITS III, IV, V, VI, VII, VIII, IX and X

6. Housing accommodations for Collier County:

a. Camps

Maximum Capacity	Number	Occupancy(peak)
Less than 10 persons		
10 - 25 persons	28	587
26 - 50 persons	37	1353
51 - 100 persons	24	1572
More than 100 persons	10	1541
*	99	5053

b. Other housing accommodations

Type	Number	Occupancy(peak
Farms	70	2200
Other locations **	1570	14747

c. Append map showing location of camps, roads, clinics, and other places important to project.

* PERMITTED CAMPS ONLY

** PRIVATE HOMES PLUS NON-PERMITTED

PRETEST DRAFT
1967
Project No. MG-18E (68)
Date submitted 5/14/68

COLLIER COUNTY

PART II MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of visits
	Total	Male	Female	
Total	2075	905	1170	2182
Under 1 year	231	103	128	268
1 - 4 years	319	149	170	363
5 - 14 years	315	131	184	331
15 - 44 years	841	299	542	801
45 - 64 years	357	211	146	407
65 and older	12	12	0	12

2. **Patients hospitalized:**

Age	Number of patients			Hospital Days
	Total	Male	Female	
Total	222	88	134	948
Under 1 year	78	44	34	261
1 - 4 years	9	7	2	28
5 - 14 years	3	2	1	27
15 - 44 years	109	18	91	401
45 - 64 years	23	17	6	231
65 and older				

3. **Patients receiving dental service:**

Item	Total	Under 15	15 and older
a. Number of migrants examined: total		1000	
Number of decayed, missing, filled teeth-			
Average DMF per person			
b. Individuals requiring services: total		457	
Cases completed		99	
Cases partially completed		209	
Cases not started			
c. Services provided: total			
Preventive		35	
Corrective		765	
Extraction		541	
Other			
d. Patient visits: total			

4. **Immunizations provided:**

Type	Incomplete series	Completed immunizations, by age					Boosters, revaccinations
		Total	Under 1 year	1-4	5-14	15 and older	
All types		2077	357	572	434	99	615
Smallpox	0	170	31	68	33		38
Diphtheria		495	70	97	95	49	184
Pertussis		298	70	92	27		109
Tetanus		496	70	97	95	50	184
Polio		377	75	115	87		100
Typhoid		0					
Measles		241	41	103	97		
Other (specify)							

Pretest Draft
1967
Project No. MG-18E (68)
Date submitted 5/14/68

5. Medical conditions found by physicians among outpatients, by age of patient

COLLIER COUNTY

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
I	Infective and parasitic dis.	131	6	16	38	30	37	4
	Tuberculosis	31			1	10	16	4
	Venereal disease	14	3	3	2	6		
	Measles	15	1	8	6			
	Infestation with worms	8	1	3		3	1	
	Dermatophytosis & other infections of skin	57	1	1	24	11	20	
	Other	6		1	5			
II	Neoplasms	10			1	5	4	
	Malignant	6				2	4	
	Benign & unspecified	4			1	3		
III	Allergic, endocrine, metabolic, and nutritional dis.	81	5	12	16	24	24	
	Diabetes	16			3	5	8	
	Malnutrition	28	4	11		1	12	
	Other	37	1	1	13	18	4	
IV	Dis. of blood and blood-forming organs	12		10		1	1	
	Anemias	11		10		1		
	Other	1					1	
V	Mental, psychoneurotic and personality disorders	43		1	1	35	6	
VI	Dis. of nervous system and sense organs	115	11	30	20	21	33	
	Cerebro-vascular disease (stroke)	6	1	1			4	
	Eye diseases	36	5	15	13	2	1	
	Dis. ear and mastoid process	39	5	10	7	17		
	Other dis. of nervous system	34		4		2	28	
VII	Dis. of circulatory system	55				2	50	3
	Rheumatic fever							
	Diseases of the heart	32				2	28	2
	Hypertension & other dis. circulatory system	23					22	1
VIII	Dis. of respiratory system	562	111	144	112	81	111	3
	Upper respiratory	224	65	52	29	36	40	2
	Influenza and pneumonia	181	27	69	53	16	16	
	Bronchitis	119	18	20	25	27	28	1
	Other	38	1	3	5	2	27	

5. Medical conditions found by physicians among outpatients, by age of patient (Cont)

Pretest Draft
1967

COLLIER COUNTY

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
IX	Digestive system diseases	270	108	67	12	54	29	
	Teeth and supporting structures	12		1	3	7	1	
	Gastroenteritis, colitis	88	17	9	4	35	23	
	Other	170	91	57	5	12	5	
X	Dis. of genito-urinary system	56	3	1	1	36	15	
	Urinary system diseases	—	3	1	1	36	15	
	Genital system diseases							
XI	Deliveries and complications of pregnancy	19				18	1	
	Complications of pregnancy	19				18	1	
	Deliveries							
	Complications of puerperium							
XII	Skin diseases	210	12	34	72	57	34	1
	Impetigo	49	1	16	16	12	4	
	Other	161	11	18	56	45	30	1
XIII	Dis. of bones & organs of movement	24		5	5	9	5	
XIV	Congenital malformations	4	2	1	1			
XV	Dis. of early infancy	9	6	3				
XVI	Symptoms, ill-defined cond.	66	3	7	5	30	21	
XVII	Accidents, poisonings, violence	162	1	29	45	50	36	1
	TOTAL OF CATEGORIES I-XVII	1829	268	360	329	453	407	12
SUPP	Special conditions, examinations, without sickness:Total							
	Prenatal, postnatal care							
	Physical examination							
	Immunizations							
	Surgical or medical after-care, follow-up	5		3	2			
	Fitting prosthetic devices							
	Other							
	Family Planning	348				348		

PRETEST DRAFT - 1967
Project No. MG-18E (68)
Date submitted May 14, 1968

COLLIER COUNTY

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number
a. Visits to homes	604
b. Total households served	721
c. Visits to schools, day care centers: total	160
d. Migrants presenting health record on request (PHS 3652)	795
e. Migrants given health record	1250
B 1-Total Individuals Served	1248

Services provided:	Number
f. Health supervision, counselling, teaching, demonstrating care [illegible] ~~homes~~	3913
g. "Sick call" (nursing clinics)	381
h. Referrals for medical or dental care: total	2248
Within area: total	1345
Number completed	1345
Out of area: total	903
Number completed	903
i. Other (specify) Family Planning	348

2. Sanitation services

Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units: Total number	Housing Units: Covered by permits: Number	Housing Units: Covered by permits: Maximum capacity	Dormitories: Total number	Dormitories: Covered by permits: Number	Dormitories: Covered by permits: Maximum capacity
Camps	126	99	123	97	4931	3	2	122
Urban or other locations	1640		1640	0				

Table B. Inspection of living and working environment of migrants

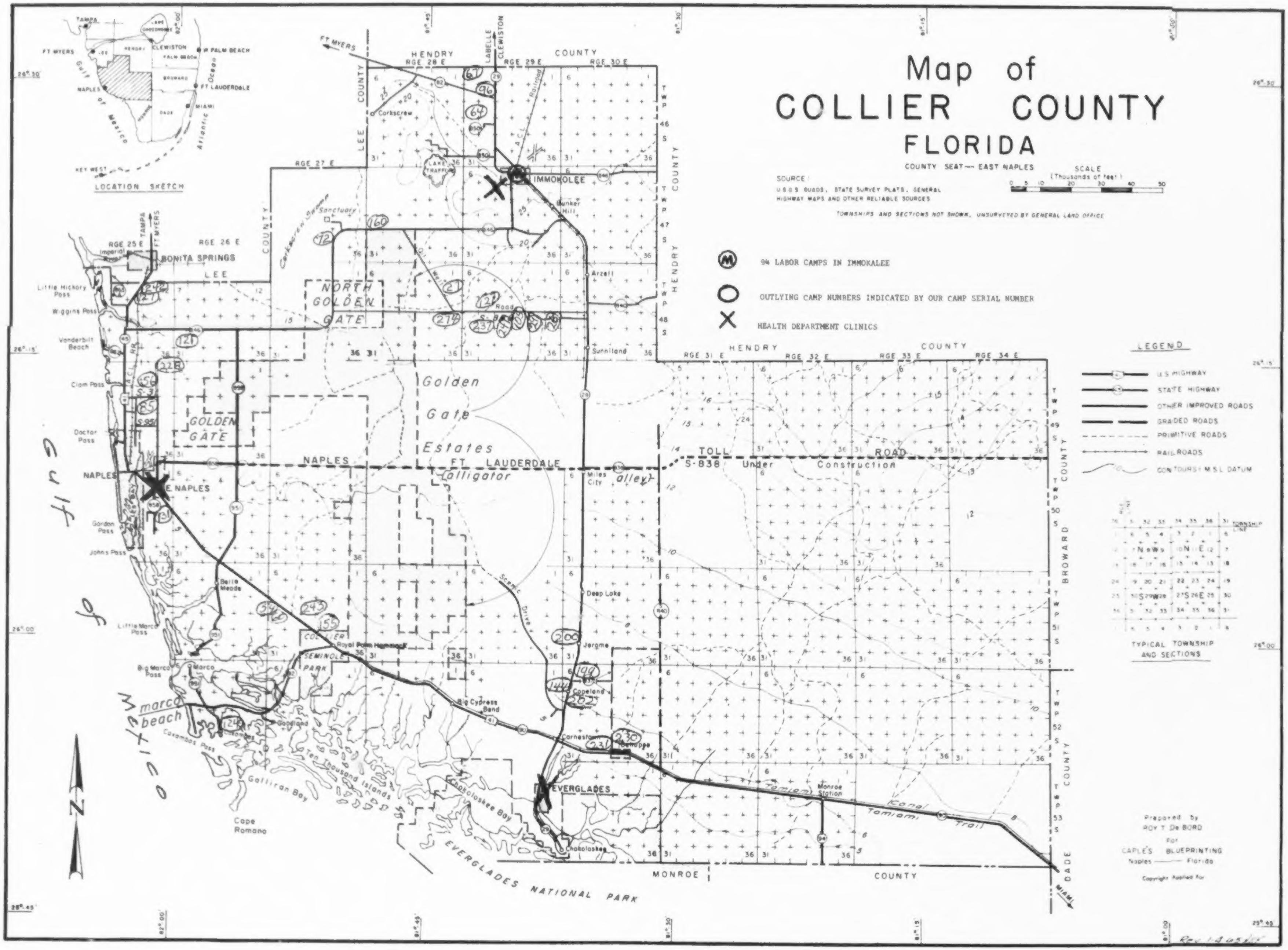
	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	129	255	150	123
b. Sewage	265	762	109	102
c. Garbage and refuse	251	815	234	218
d. Housing	166	455	170	170
e. Safety	126	95	25	25
f. Food handling	44	64	20	20
g. Insects and rodents	126	455	50	40
h. Recreational facilities	126	126	2	2
Working environment				
a. Water	0	0	0	0
b. Toilet facilities	0	0	0	0
c. Other				

* Locations - camps or other locations where migrants work or are housed

6

Map of
COLLIER COUNTY
FLORIDA

COUNTY SEAT — EAST NAPLES


SOURCE:
U.S.G.S. QUADS, STATE SURVEY PLATS, GENERAL HIGHWAY MAPS AND OTHER RELIABLE SOURCES
SCALE (Thousands of feet)
0 5 10 20 30 40 50
TOWNSHIPS AND SECTIONS NOT SHOWN, UNSURVEYED BY GENERAL LAND OFFICE
Ⓜ 94 LABOR CAMPS IN IMMOKALEE
○ OUTLYING CAMP NUMBERS INDICATED BY OUR CAMP SERIAL NUMBER
X HEALTH DEPARTMENT CLINICS
LEGEND
U.S. HIGHWAY
STATE HIGHWAY
OTHER IMPROVED ROADS
GRADED ROADS
PRIMITIVE ROADS
RAILROADS
CONTOURS: M.S.L. DATUM
TYPICAL TOWNSHIP AND SECTIONS
TOWNSHIP LINE
LOCATION SKETCH
TAMPA
LAKE OKEECHOBEE
FT MYERS
HENDRY
CLEWISTON
W PALM BEACH
PALM BEACH
BROWARD
FT LAUDERDALE
NAPLES
DADE
MIAMI
MONROE
KEY WEST
Gulf of Mexico
Atlantic Ocean
HENDRY COUNTY
LEE COUNTY
BROWARD COUNTY
DADE COUNTY
MONROE COUNTY
RGE 25 E
RGE 26 E
RGE 27 E
RGE 28 E
RGE 29 E
RGE 30 E
RGE 31 E
RGE 32 E
RGE 33 E
RGE 34 E
TWP 46 S
TWP 47 S
TWP 48 S
TWP 49 S
TWP 50 S
TWP 51 S
TWP 52 S
TWP 53 S
FT MYERS
LABELLE
CLEWISTON
TAMPA
Corkscrew
Lake Trafford
IMMOKALEE
Bunker Hill
A.C.L. Railroad
Corkscrew Sanctuary
Arzell
Sunniland
BONITA SPRINGS
Imperial
Little Hickory Pass
Wiggins Pass
Vanderbilt Beach
Clam Pass
Doctor Pass
NAPLES
E. NAPLES
Gordon Pass
Johns Pass
NORTH GOLDEN GATE
GOLDEN GATE
Golden Gate Estates
NAPLES FT. LAUDERDALE TOLL ROAD S-838 Under Construction
alligator alley
Miles City
Scenic Drive
Deep Lake
Jerome
Copeland
Belle Meade
Little Marco Pass
Big Marco Pass
Marco
marco beach
Caxambas Pass
Goodland
COLLIER SEMINOLE PARK
Royal Palm Hammock
Big Cypress Bend
Cornestown
Ochopee
EVERGLADES
Chokoloskee
Chokoloskee Bay
Ten Thousand Islands
Gullivan Bay
Cape Romano
EVERGLADES NATIONAL PARK
Tamiami Canal
Tamiami Trail
Monroe Station
MIAMI
Gulf of Mexico
N
67
96
64
160
72
21
127
274
237
121
22B
65
85
S-3
S-95
31
200
199
144
262
230
231
243
155
342
124
26°30'
26°15'
26°00'
25°45'
82°00'
81°45'
81°30'
81°15'
81°00'

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Rev 1-4-65

NARRATIVE REPORT
COLLIER COUNTY HEALTH DEPARTMENT
MIGRANT HEALTH PROJECT
May 1, 1967 thru April 30, 1968

The period covered by this report is May 1, 1967, thru April 30, 1968. The objectives listed in the last approved application were as follows:

1. To increase all health services to the migrant population. This was achieved by: (a) Starting a night clinic on June 1, 1968, for three hours, one night each week. Services provided were family planning, immunization and medical referrals as necessary. (b) By school system furnishing one nurse for four months and one nurse for one month. This is reflected in the nursing services report which follows.

2. To have all migrant labor camps in Collier County permitted. During the past year, we had 99 permitted camps; an increase of 14 per cent over the previous year when 87 camps were permitted.

3. To increase the sanitarians' knowledge of the migrant program. Twenty in-service staff meetings, several conferences with county and government leaders, the State Board of Health, the County School System, educational conferences and communication with other counties.

4. To appraise and inform the public of the migrant program. This was achieved by talks to civic groups by staff members, meetings and conferences with civic groups, plus generous newspaper and television exposures.

5. To require all permanent camps to have inside sanitary and cooking facilities and refrigeration. This was accomplished.

Additional objectives for the coming year will be:

1. To see that all work areas are provided with a potable water supply and to upgrade the substandard housing in the camps and at private homes wherever possible. This shall be done by a strict enforcement of our county building and zoning ordinances.

2. To increase direct medical services to the migrant worker and his family and to improve the continuity of medical care by employing a full-time clinician for the Immokalee Clinic.

3. To increase both dental and x-ray services to the migrant worker by providing facilities for these services in the Immokalee area.

4. To motivate the community to provide increased support to the Migrant Health Project.

The significant changes in the migrant situation from the previous year are: First, in the ethnic composition, we believe it to be the following for the 1967-68 year:

50% Texas-Mexican
35% American Negro
10% Caucasian
5% Puerto Rican

The 1966-67 report listed them as:

30% Texas-Mexican
25% American Negro
25% Caucasian
20% Puerto Rican

Second, the season this year was approximately three weeks longer due to unseasonably cold weather in March and drought conditions during the same period. The only change that this made in the migrant situation is that the migrants remained in the county longer. There seems to be a trend toward permanent residence and out-migration from the area.

Because of the above facts, the need for health services remained at a higher level during the latter part of the season than in the previous year. The influenza epidemic also contributed to the increased need for health services.

Family Health Service Clinics are held in Naples, Immokalee, and Everglades. Schedules and details on these clinics follow in the Nursing Service report.

Dental service is provided in the Naples Clinic on an elective and emergency care basis. Dental clinics are held Monday thru Friday from 8:00 a.m. to 12:00 noon and 1:00 p.m. to 5:00 p.m. The Dental clinic is staffed by one non-project dental preceptor, one project dental assistant for eight months, and one non-project dental assistant for one month. Arrangements for medical care outside the clinics are detailed in Exhibit 11, which follows.

There has been no formal health education program in the project. Referrals for additional care are listed in Exhibit 11. The results from these referrals have been excellent. Hospital care, instituted during the past year, has been well received by both the Naples Community Hospital and the migrants. All migrant hospital admissions are reported to the health department within 48 hours. Eligiblity for hospitalization under Project "M" is determined by a project public health nurse who personally interviews the patient. This has increased the workload of the nursing and clerical staff. This, in turn, has increased the need for additional nursing and clerical personnel. Personnel involved in the medical and dental services are as follows:

3 Full-time project nurses
2 Full-time non-project nurses
4 Full-time non-project nurses (15% project work)
1 Non-project nurse supervisor (50% project work)
1 Full-time nurses aide
1 Part-time nurses aide, non-project for 10 months
1 Full-time Community Health Worker, non-project for 3 months
1 Volunteer private physician (1 day per month)
1 Non-project dentist doing 65% project work
1 Project dental assistant for 8 months
1 Non-project dental assistant for 1 month
1 Non-project physician (Director) 50% project work for 7 months
1 Non-project physician (Director) 50% project work for 2 months
1 Acting Health Director, part-time from FSBH, non-project, 50% project work
1 Community Health Worker, full-time, non-project, 3 months

During the year the Collier County schools provided one full-time R.N. for five months; one full-time LPN for two months; and one full-time clinic aide for one month. The Director of the Collier County Health Department resigned on November 30, 1967. An Acting Director was provided by the Florida State Board of Health for three months. A full-time Director was employed as of March 1.

It is anticipated that a full-time physician will be needed for the Immokalee clinics during the coming year to increase the medical services and to improve the continuity of medical care. There is also a need for additional clerical personnel which would free the nurses to do more actual nursing care.

Hospital admission of migrant workers is attained by referral from private physicians and through the Emergency Service of the Naples Community Hospital. There is no provision for payment to the attending physician in these cases. The private physicians have given freely of their time to provide inpatient care for the migrant worker. All hospital admissions are reported to the Collier County Health Department within 48 hours. Eligiblity for inpatient care under the project is determined by a public health nurse during a personal interview with the hospitalized migrant patient. This has been very well received by both the Naples Community Hospital and the migrant. Provision should be made for payment of the physician responsible for this inpatient care. Availability of the project hospitalization forms has been poor during the past year. The voluminous required paper work could be expedited by making these forms more readily available.

Other health care activities include the Environmental Health Section composed of:

Sanitation Director I	part-time
Senior Sanitarian	part-time
Sanitarian (retired 3/1/68)	full-time
Sanitarian Trainee (5 mos./7 mos.)	part-time
Sanitarian Trainee (11 mos./San. 1 mo.)	full-time
Sanitarian Trainee	part-time
Sanitarian Trainee (emp. 2/19/68)	full-time
Clerk-Typist II (resigned 3/15/68)	part-time
Clerk-Typist II (emp. 3/4/68)	part-time

This section carries on a complete Environmental Health program directed toward improving the living and working conditions of the migrant workers. A more detailed description follows.

The Mental Health Section comprised of:

1 Full-time non-project Mental Health Worker
1 Part-time Psychologist
1 Part-time Psychiatrist

The services of the mental health program are available to the migrant workers. Both out-patient treatment and consulting, and in-patient care in state mental hospitals are provided for them. Psychotheraputic drugs are provided upon prescription of a physician.

Our relationship with the growers has been excellent. They have been most cooperative in improving the migrant housing and working environment. They are genuinely concerned with the welfare of the migrant.

The County Welfare Department provides funds for hospitalization of migrant workers who are victims of tuberculosis.

The Collier County Medical Society has been most cooperative in the Migrant Health Program. They have given freely of their time in consultation concerning treatment of patients. They have assisted in the improvement of the health program, donated drugs for the program, and have taken the responsibility of the treatment of patients within the health department during the absence of the director.

There are two migrant day care centers in the county. The public health nurses act as resource persons for these centers.

The Environmental Health Section has worked with Farm Labor Representatives at all governmental levels. The relationship is good and has been of mutual benefit to both parties.

The Agricultural Extension Agency has been most helpful in supplying statistical information required for this report.

Some of the migrant labor crew leaders are also camp operators. They have been very cooperative generally on our program. They are very helpful locating patients for purposes of identification, follow-up medical care and planning continuity of health care for workers under their supervision.

Other community groups have donated time and funds to the project. These are listed in the Nursing report which follows, The Cancer Society donated $1,200 toward the project bus which is utilized to transport migrants to and from health centers. The Lion's Club has provided glasses for six migrant workers.

Our relationship with Migrant Health projects in other counties has been beneficial in the exchange of knowledge concerning specific problems, medical referrals, and certification for hospitalization, and providing previous medical records.

The most desirable change is in the coordination and efficient utilization of the above groups and agencies. This, of course, only points up the dire need for additional personnel for the project.

Consultation or other assistance received from outside the local project area are as follows:

1. State Nursing Consultant
2. Crippled Children's Nurse Consultant - Miami
3. Tumor Clinic, Mt. Sinai Hospital, Miami Beach - Secretary & Physician
4. Anti-Convulsive Clinic, Dade County
5. Florida Council for the Blind Counselor - Tampa area
6. Children's Variety Hospital, Outpatient Department - Miami
7. Vocational Rehabilitation Counselor - Ft. Myers
8. United States Veterans Administration Hospital - Miami
9. Cardiac Hospital - Miami
10. Tuberculosis Hospital - Lantana
11. Lee Memorial Hospital - Ft. Myers
12. State Tuberculosis Association - Ft. Myers
13. Migrant Health Project Coordinator, Florida State Board of Health

The importance of these sources is inestimable.

There is difficulty in obtaining consultation and assistance for the mentally retarded. This is because of the residence requirements of the state. This area will be improved in the future.

Orientation and in-service training has been extensive during the past year. These activities are listed as follows and have been most beneficial in the carrying out of the migrant program.

The Nursing Section attends meetings at monthly intervals for improvement of organization and implementation of the Migrant Projects. New nurses are required to attend Florida State Board of Health orientation sessions for a period of two months prior to obtaining permanent status.

The director and/or sanitarian attend Educational Conferences of:

Florida Association of Sanitarians
Florida Public Health Association
International Association of Milk Food and Environmental Sanitarians
Emergency Health Services Short Course

We participated in Pre-School Health Workshop. Furnished a list of local migrant growers, etc. for Congressional Committee. We held a workshop for Peace Corp students.

We attended meetings called by Governor Kirk and his staff with other area representatives. We furnished information to Congressman Paul Rogers at his request. We conducted a tour of the migrant area of Immokalee for Governor Kirk and his staff. We participated in community meetings with members of Governor Kirk's staff together with Federal, State, County, and Local officials; migrants, growers, businessmen, and others. We conducted an investigation and interview of a local migrant family at the request of the Governor's staff. The director and sanitarians attended a Supervisor Short Course; Sewage Operator Training School and several Gulf Coast and Florida Public Health Association meetings. We sent sanitarians to Lee and Broward counties for orientation. We sent one sanitarian to the Basic General Sanitation Course in Jacksonville.

Generally, in spite of the shortage of personnel and funds, the Migrant Health Program during the past year has been very beneficial to the migrant farm worker and his family. In large part most objectives set forth in the last report were achieved. However, much remains to be accomplished. Many problems were encountered in achieving these objectives. Because of unrealistic salaries it is impossible to compete for competent personnel. Without competent clerical personnel, there is a drain on the time of professional employees which in turn results in inefficient utilization of their time. Limited facilities in the Immokalee Clinic has made transportation of patients for x-ray and dental service necessary. If and when these services are offered in Immokalee, much time and expense may be eliminated.

Employees dedication, excellent relations with the Medical Society, Civic Organizations and Citizens of Collier County are the strong points toward achieving our objectives.

In planning for the overcoming of weakness in the program, we will need additional personnel, additional facilities, and additional funds.

Salary increases certainly will induce employees to remain in Collier County.

The objectives set forth in this report will be achieved if the requested additional personnel and funds are made available. However, in the event that these are not forthcoming, we will be forced to revert to the activity and objectives as achieved in the past year. Increased services require increased funds and personnel.

NURSING

I. General description of nursing service

A. STAFF INVOLVED

Full-time project nurses	3	
Full-time non-project nurses	2	
Part-time (15%) non-project nurses	5	
Full-time project aide	1	
Part-time non-project aide	1	(10 months)
Full-time Community Health Worker (non-project, 3 months this year)	1	
Full-time Socail Worker (non-project)	4	
Full-time R.N.	1	(paid for by the school board with anti-poverty fund and assigned to H.D.)
Full-time L.P.N.	1	

The R.N. has been working five months and the L.P.N. two months

The four social workers are employed by the school and work directly under the school supervision, but work closely with the health department. The migrant population increases each year as the county puts new land into agriculture. This results in a need for new personnel.

This reporting year one of the project nurses spent two months out of the county for orientation. Due to the budget cubback, one clinic aide was terminated December 31, 1967. The health director resigned November 30, 1967, and a new health director was hired March 1, 1968.

B. Specific objectives and duties (1968-69)

1. To increase health education services to the migrant population.

    a. By increased use of visual aids.
    b. By increased use of literature.
    c. By increased personal contact of PHN and migrant.

2. To increase nursing services to outlying camps by providing camp occupants with immunization, family planning information and supplies, medical referrals as necessary, and other services ordinarily provided during course of home visits.

3. To broaden the nursing staff knowledge of effective operational techniques.

    a. By bi-monthly staff conferences involving exchange of information relative to patient problems and their possible solutions, plus individual presentations of recent innovations in the field of medicine and nursing.

b. By scheduling field trips to other counties participating in the projects.

C. Relationship with and involvement of migrants, growers, other project staff members, individuals and groups, etc.

1. Personal contact with the migrants in clinics, schools, homes, and in camps.

2. Contact with growers is generally through the sanitarians, except in cases where nurses try to locate migrants for a specific purpose.

3. Work with other project staff to improve migrant services.

4. Volunteer service: Provided by Dr. Douglas G. McCree, Obstetrician-Gynecologist, eight hours one day a month; other physicians in the county, eight hours each day for seven days. (This was during the four months the county was without a health officer.) The County Medical Society made themselves available during this four-month time for V.D. treatment and emergency orders.

Other Clinic Volunteer Help:

Naples Community Hospital Auxiliary Women - 40 hours per month
School Volunteer Help - Approximately 300 hours per month

Groups Assisting with Migrant Health:

a. United Church Women

    1. Have furnished vitamins for adults, children and infants, $127.
    2. Have furnished clothing for infants, pre-school and school children as necessary.
    3. Have contributed towards the up-keep of the Immokalee Day Care Center for 50 to 60 migrant children, approximately $7,000.

b. An interested Women's group (winter residents and long-time friends, non-civic) donated layettes for expectant migrant mothers.
c. Methodist Church Women make bed pads and dressings.
d. Episcopal Church Women make approximately five layettes monthly.
e. Lutheran Church Women, infant and pre-school clothing and other personal items as needed.
f. Medical Society gives sample medicines to clinic, $600.
g. Salvation Army has furnished transportation for male, adult migrants to return back to their family when health conditions were such that they could not work. They have also assisted in buying food for needy migrants when necessary, $350.
h. Florida Migrant Ministry provides the facilities for 50 to 60 children in a Child Care Center and the Mennonite Church provides the staff. Donated clothing is given out or sold at 10¢ a piece and the proceeds used to feed and pay rent for emergency needs of migrants and the up-keep of the nursery. At Christmas time, an article of new clothing and toys were given to each child in the

Community of Immokalee as contributed from the migrant ministry.

i. Other individuals from the community donated food, clothing, toys, and (approximately $500 worth) transportation when needed. The local migrant committee functions with $700 assistance of food and needs not provided by project.

j. County Welfare - drugs for treatment in Clinics, $85.

5. Baptist church minister, Rev. Maxwell, who works with migrants in the Eastern Seaboard States - Florida, South Carolina, North Carolina, Virginis - visited Immokalee during the season and compared migrants' health - many children - and noted that he sees great improvement in their health. He attributes this progress to the Project.

D. Consultation received from outside the project: type and source

1. State Nursing Consultant
2. Crippled Childrens Nurse Consultant - Miami
3. Tumor Clinic, Mt. Sinai Hospital, Miami Beach - Secretary & Physician
4. Anti-convulsive Clinic - Dade County
5. Florida Council for the Blind, Counselor - Tampa area
6. Children's Variety Hospital (out-patient department) - Miami
7. Vocational Rehabilitation Counselor - Ft. Myers
8. United States Veterans Hospital - Miami
9. Cardiac Hospital - Miami
10. Tuberculosis Hospital - Lantana
11. Naples Community Hospital
12. Lee Memorial Hospital - Ft. Myers
13. Collier County Medical Society
14. Visiting Nurses Council - Collier County
15. State Tuberculosis Association - Ft. Myers

E. Consultation needed from outside

Mental retardation institutional service

II. Services provided to migrants

A. General description of nursing services to migrants and families, including kinds of problems encountered and solutions:

1. Communicable disease control

2. Venereal disease control
3. Tuberculosis control
4. Maternal and Child Health Services
5. School Health
6. Adult: acute and chronic diseases, curative and preventive services
7. Mental Health services

CLINIC SCHEDULE: Health Department, Naples

Mondays:	8:30 - 10:30 a.m.	Prenatals	2 Nurses
	10:30 - 11:30 a.m.	V.D. & Medical Patients	
	1:00 - 4:00 p.m.	Immunization, Birth Control Pills and T.B. Skin Tests	
Tuesdays through Fridays:			
	8:00 - 9:00 a.m.	Medical	1 Nurse
	4:00 - 4:40 p.m.	Family Planning	
	1:00 - 3:00 p.m.	X-ray Clinic	1 Nurse
Wednesdays:			
	1:00 - 3:00 p.m.	X-ray Clinic	1 Nurse

CLINIC SCHEDULE: Health Department, Immokalee

STAFF: 2 Clerks; 1 full-time, one part-time Aide; Interpreter; and Nurses (4 to 5)

Mondays:	9:00 - 12:00 noon	New Expectant Mothers	1 Nurse
	9:00 - 4:00	Medical	1 Nurse, 1 Aide
	7:00 - 9:00 p.m.	Night Clinic (all services)	1 Nurse, 1 Aide, 1 Interpreter, 1 Clerk
Tuesdays:	1:00 - 4:00 p.m.	Family Planning (Pills)	1 Nurse
		Medical	1 Nurse, Aide, Clerk
	9:00 - 12:00 noon	School visits by all nurses	
Wednesdays:			
	9:00 - 12:00 noon	Expectant Mothers & Infants, Physicians' Clinic	5 Nurses 2 Aides
	1:00 - 4:00 p.m.	Medical	
Thursdays:			
	9:00 - 4:00 p.m.	Immunizations (Innoculations)	
		Family Planning	1 Nurse, 1 Aide
		Medical	1 Nurse, 1 Aide

Fridays: 9:00 - 12:00 noon Medical
1:00 - 4:00 p.m. Field Visits by all nurses

CLINIC SCHEDULE: Health Department, Everglades

Tuesday: 10:00 - 12:00 noon General Clinic
1:00 - 3:00 p.m. General Clinic

Thursday: 1:00 - 4:00 p.m. General Clinic with physician, twice a month

Some of the problems and solutions are narrated in the following case histories:

> A family of eight coming to the county for the season includes a 13-year-old epileptic girl who was referred by the PHN in 1962 to the Anti-convulsive clinic at the City of Miami, 100-plus miles away, where she had regular checkups and received medication when in the county. The family left with the season. The mother came to the health department in January, 1967, and reported to the clerk that the child was fine and gave an address since their return. The PHN checked at the school and learned she was in a Special Education class but had not been attending for weeks. The PHN contacted the parent (mother) and learned of the medication schedule and that medical appointments were received locally (Naples and Immokalee). Following one medical visit the doctor referred the patient again to the anti-convulsive clinic and added the diagnosis, "Diabetes Insipidus." The anti-convulsive clinic requested special tests to rule out "Diabetes Insipidus." These tests were done in the local hospital laboratory and financed by the project. Medications were provided by the project when necessary. The patient had increased seizures when told by the school principal that she could not enter the sixth grade as passed, due to seizures and retardation. Much emotional support was given to the patient and her mother who came to the health department frequently for various assistance.
>
> The patient was admitted to the hospital in the county in October, 1967, on project funds, for diabetes control and was regulated with insulin. Due to an anti-convulsive drug reaction, the patient was referred to the health department dentist and after numerous visits had improved teeth and gums. The patient studied at home until January, 1968, when she was notified by the school to return to the fifth grade - which made her happy.

This case history shows the close inter-relationships with the health department staff, patient, family, school, and other resources and what has been accomplished by united and constant efforts. The long term goal is to have the patient independent and self-supporting upon completion of formal or vocational education; also, to sterilize the patient to prevent pregnancy.

One prenatal patient (Grovida I) who came to the health department for the first time in 1965, received eight routine checkups and health teaching sessions. One value the PHN tried to teach the patient was better hygiene and the importance of a separate bed for the baby upon its arrival. The patient was influenced by her mother-in-law and husband who proudly stated that the mother-in-law slept with all her babies. Also, in discussing family planning, the patient was not interested and gave as the reason the "pills ruined two sisters-in-law's health." The nursing staff again welcomed the patient to the maternity clinic in December, 1967, when she told the PHN that she had taken birth control pills, but had not taken them right, and that her husband did not want her to take pills or use any method of birth control. The IUD was suggested and following the patient's delivery, as the Project PHN made the home visit, the patient approached the nurse about family planning. After more instruction with the use of literature, on various methods, and discussions of advantages and disadvantages of each method, the patient agreed to receive service offered at the health department. She kept her appointment at six weeks postpartum and received an IUD without her husband's knowledge, in spite of her statement that her sister-in-law had an IUD for six weeks and got pregnant.

Following this delivery too, the patient showed improvement in hygiene of the baby, self and the baby slept in a separate bed. The mother and PHN were both pleased.

T.B. casefinding and follow-up has been given high priority due to the high incidence of T.B. in migrants. One problem encountered is the lack of a requirement for a skin test or x-ray or record on a health card for field and packing house workers who handle fresh vegetables that are consumed in a raw form.

T.B. skin testing has been done on first and sixth grade pupils in 14 schools, prenatal patients in clinics, and migrants in five camps: McClains, Walkers, 6-L's, Delashment, and Camp Happy. In the camps about 20 per cent tested were positive and were followed-up with x-rays, etc.

The mobile chest x-ray unit provided service for Collier County during three weeks in January. A total of 6,869 x-rays were taken; approximately 2,010 of which were migrants, including five camps - 6-l"s, Duda, Basso Camp, Hall, HLH Products - in evening. Four migrant active cases were discovered from this survey. A summary report of the survey was submitted to the Florida State Board of Health and Tuberculosis and Respiratory Disease Association of Southwest Florida after which a reply later was received congratulating the entire department for having done an excellent job on follow-up (see letter). During the year, Collier County admitted to the State T.B. Hospital in Lantana, Florida (165 miles one way) 42 cases, 31 of these being migrants. Hospitalization expense, transportation, and hospital clothing is furnished by county welfare.

A 28-year-old Spanish male in the county for 3½ months was found to have active tuberculosis. He was the wage earner of the family with a wife and six children. Follow-up on the family has revealed seven active cases - two of his children, and one adult, and four more children who are relatives. The community has responded to the family's needs by providing rent, food, and clothing.

A single, Negro male patient was admitted to and discharged from Southeast TB hospital in Lantana in 1965. He was uncooperative for follow-up due to alcohomism and left the county in April, 1967, before a positive sputum report was received in May. The patient was unable to be followed by Migrant Health Referral because he left the area without a forwarding address or notifying the health department. At the beginning of the season, the patient returned to Collier County and was found unexpectedly. He was immediately readmitted to the Southeast T.B. Hospital in Lantana where he was also diagnosed as having "Tetanus." One hour after his admission he was in surgery for an emergency tracheotomy. He recovered well from both diseases but due to his chronic alcoholism, he is not following doctor's orders and probably will need rehospitalization again. This example is typical of the problems encountered.

School and Health Education:

Great emphasis is placed on school health, but the majority of health service has been through clinic services. The social workers in the schools work closely with the PHN and refer the children to the PHN in school and the health department. The social workers transport many of the children and parents to clinics (funded by Title 19).

A two-day orientation by the Florida State Board of Health Vision Screening Consultant, assisting the Project, was provided to train approximately 60 volunteers to do vision screening in fourteen schools. This reduced the nurses' and school personnel's time in preliminary screening. Approximately 691 visual tests and rechecks were done by the PHN and more than a hundred children were referred for eye medical examinations. The Florida Council for the Blind received most of these referrals (see letter from the Florida Council for the Blind).

The Naples Lion's Club assisted in medical examinations and glasses for some children (Immokalee has no active Lions Club).

A four-hour work shop for teachers was conducted on V.D. by the Florida State Board of Health to enable teachers to integrate V.D. in their health education. The PHN gave support to the program. The film "A Quarter Million Teenagers" was shown to all the sixth grade and up students and some fifth graders in Immokalee and literature on V.D. distributed to each student. Approximately 20 health films have been loaned from the State Board of Health and shown by the PHN in schools. The county owns the series of Migrant Health films - "Safe Food," "A Healthier Place to Live," and "Keep Clean, Stay Well." This series has been shown to the 100 adults in Adult Education, the Peace Corp students in orientation prior to serving in Liberia, and Home Economics students in high school. They were also shown in Night Clinics.

Audiometer testing was done by the School Speech and Hearing Therapist (funded by a Federal Project.) Defects were referred to nurses for follow-up. No remedial service is available in the county for this.

Bi-weekly scheduled visits are made to each school by three Project nurses and five non-project nurses. All but two of the 14 schools have migrants.

The Presbyterian Church Youth Group, sponsored a six-hour health fair to an elementary school one Saturday. Two volunteer physicians and one public health nurse were involved in giving 146 physicals to migrant students, also, a health kit containing a toothbrush, toothpaste, soap, comb, washcloth, and towel was given to each student. This Health Fair was effective health education.

The lack of clinic space in the Immokalee Health Department clinic prevents and hinders the amount and kind of service provided.

Space is needed for x-ray and dental equipment and an area large enough to show health education films and conduct health classes and do demonstrations.

For chest x-rays and dental care, the patients have to be transported 42 miles one way to Naples.. This takes valuable nurses' time arranging transportation, by volunteers and the Community Action Fund, as the project bus is usually transporting patients to Miami.

Transportation still remains a problem as it takes more than 25 per cent of one

EK
CBP
GS

Florida Council For The Blind
(A STATE AGENCY)
REPLY TO:

109 WEST PENSACOLA, TALLAHASSEE 32301 ☐
P. O. BOX 1151, DAYTONA BEACH 32015 ☐
P. O. BOX 2299, DAYTONA BEACH 32015 ☐
1111 WILLIS ST., DAYTONA BEACH 32014 ☐
P. O. BOX 669, PLAZA BLDG., SUITE 106, PENSACOLA 32502 ☐
VENDING STAND DISTRICT OFC., 650 W. 20TH STREET, HIALEAH 33010 ☐
P. O. BOX 1229 416 S. TAMPANIA, TAMPA 33601 ☒
1350 N. W. 12TH AVENUE, MIAMI 33136 ☐
215 MARKET STREET, JACKSONVILLE 32202 ☐
125 LAKE VIEW, W. PALM BEACH 33401 ☐
417 S.W. 8TH ST., GAINESVILLE 32601 ☐
1150 S. W. 1ST STREET, ROOM 208, MIAMI 33130 ☐

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April 18, 1968

Miss Edna Keener, PHN
Collier County Health Department
Immokalee Branch Office
P.O. Box 925
Immokalee, Fla.

Dear Miss Keener:

I am taking the liberty of acknowledging your communication of 4/10/68 addressed to Mr. Hall.

Mr. Hall's letter concerning the necessity to schedule other than emergency services into our next fiscal quarter was the result of an urgent review of remaining funds available on a state-wide basis. Our funds for eye medical care for children and non-employable adults had been reduced to such an extent that we found it necessary to curtail all but emergency spending. At that time, we had less than $2700 to cover emergency expenditures in 22 counties of southwestern Florida between that date and June 30.

Since that time, we have authorized bilateral retinal detachment surgery for one of your Collier County patients on the basis of an urgent telephone call from the Bascom Palmer Eye Institute. We will be very fortunate if we escape with a hospital bill on that particular case of less than $600, so our reserve for emergencies could very well be completely exhausted well before June 30. Other areas of the state face similar situations.

Perhaps you will be interested to know that the number of referrals per thousand of general population in Collier County is very nearly six times that of the state-wide average, and Collier stands 11th in the state in the total number of referrals by county.

We very much appreciate the help which the Public Health Nurses have given us in your area, and welcome the savings that have been accomplished by furnishing free transportation from Collier County. However, I do want to make it clear that Mr. Hall was not personally responsible for any delay in routine service to his patients and to assure your staff that this was a state-wide action, and not one limited to your county.

Thanks again for your assistance in carrying out our program of eye care.

Very sincerely yours,

FLORIDA COUNCIL FOR THE BLIND
D. G. Smith
Douglas G. Smith, Area Supervisor

DGS/pjh

nurse's time arranging for appointments and notifying patients of appointments, as the Project bus has to leave Immokalee many days at 4:00 a.m. to have patients in Miami Beach (125 miles away) for an 8:00 a.m. appointment. The bus driver works many days from 12 to 16 hours. This takes extra time by nurses keeping with overtime and trying to find substitute drivers for transporting patients.

Language barriers and cultural standards remain a problem. Even with an interpreter-clinic aide the nurse feels some frustration in communication.

There has been an increase in sick patients coming to the clinic. The nurses do a rough screening and take the responsibility for making a decision if the patient needs medical attention - resulting in many referrals.

Distance to camps from clinics presents a problem for patients and the nurse in giving and receiving service.

There is only one practicing physician in Immokalee with limited laboratory facilities. The termination of the health officer reduced the efficiency of personnel and clinic schedules as the nurses had to make contact with private physicians for emergency treatments and medical advice. Dispensing of Family Planning and tuberculosis drugs had to be arranged when the assistant Health Officer from the State Board of Health was in the county every other week. Clinic schedules had to be arranged according to the private physicians that were giving their time to the clinic.

Adverse publicity given by a federally funded agency unacquainted with the county and based some distance away created a distrubance in the project personnel because of a duplication of service, etc. At this time the county citizens expressed publically the fine job the health department personnel were doing.

Maternity and child health services have been given high priority. Nurses field visits according to age were:

0 - 1	1 - 4	5 + Over
209	58	90
Nurses home visits were:		
293	447	628

In the county there were 492 births, 137 of these being migrants. One-hundred, thirty were Naples Hospital deliveries and seven were delivered by a midwife. Nurses maternal field visits came to 146 and nurses maternal office visits were 776.

Thirty-four tubal ligations were performed on migrants who had physical or emotional problems and had five or more children.

Seventy-six IUD's were inserted in the Immokalee Clinic by a volunteer physician.

The two migrant day care centers provide care for approximately 100 pre-school children. Nurses act as resource health agents for the centers and have close relationships. There is a great need for additional child care. While home visiting, the project nurse saw an elderly colored (Negro) woman who lived in a small trailer caring for 16 children under three years of age, since there was no other place for them to be cared for.

B. Health education as part of service (plan and method of implementation)

Health education was included in all types of services - ten expectant mother's classes were held in the waiting room of the health department. During night clinics, films were shown on "Safe Food," "Healthier Place to Live," and "Keep Clean and Stay Well." Each prenatal is given literature on prenatal care, Family Planning and nutrition; all are reviewed with the patient with explanations. The schools were furnished with health material and nurses were involved with presenting the material when advisable.

As literature is given, it is asked that the recipient share it with his family and friends.

C. Describe referral system used locally in your project area, pointing out successes and reasons for incomplete referrals.

(1) Medical referrals: This is in two parts and the patient takes it to a physician. He is to retain the top part and return the bottom part to the health department with the date of service and diagnosis. This has been a very successful method.

(2) PHS #3652 - Personal Health Record, is given to all prenatal; all immunizations; and others when needed. This has been very effective locally as the patient presents this card at the clinic, to physicians, and the hospital. This has helped with continuity of care.

(3) Photocopies of prenatal records are sent to the hospital in the last month of pregnancy and frequently given to the patient when leaving our area.

(4) Migrant Health Service Referrals have been used very little, as patients do not notify the health department when leaving the area.

D. Describe system used for out-of-state referrals and comment on successes and reasons for incomplete referrals.

Two methods are used for Out-of-State Referrals:

(1) PHS #3652 - The patient is instructed when given the form that it is to be carried with him all of the time and be presented to a private physician, health department, or others. This has been very well accepted by patients.

(2) Migrant Health Service Referrals are received in mail from other counties and states, but the patients do not come to the health department. Many times the form does not have enough information regarding living address and parent or crew leader to find the patient and complete the service and the referral. Some referrals were sent to other states and one example is the referral sent to South Carolina where they gave service for a child's ear surgery and completed the referral.

Hospitalization for Migrants has been a great service as it has made funds available for hospital deliveries for prenatals that were not financially able to pay and in many instances would have had to have a midwife care for them. Many acutely ill infants and children were hospitalized which probably prevented a number of deaths. This has required hours of the nurses' time in screening for qualifications.

III. General Appraisal of Nursing Program

With the impact of outpatients medical service and inpatient hospitalization, the project personnel are not adequate to carry out a full planned health program - too much of the nurses' time is involved in clinic activities and referrals to other agencies, leaving limited time for home visits and school health. A medical/social worker is needed because the migrant has learned he can receive services from the health department so he brings all his problems to the nurses. The present staff is well organized and works effectively under the present conditions. The evidence of community groups sharing in the Migrant Health Service is shown in our volunteer services - under I-D list referral resources for migrants.

IV. Specific plans for future with reference to any modification of objectives, procedures, staffing, relationships, etc. in the light of this year's experience.

Nursing objectives for May 1, 1968, through April 30, 1969:

1. To increase health education services to the migrant population.
    - a. By increased use of vidual aids.
    - b. By increased use of literature.
    - c. By increased personal contact of PHN and migrant.
2. To increase nursing services to outlying camps.
    - a. By providing camp occupants with immunizations, family planning information and supplies; medical referrals as necessary, and other services ordinarily provided during course of home visits.
3. To broaden the nursing staff knowledge of effective operational techniques.
    - a. By bi-monthly staff conferences involving exchange of information relative to patient problems and their possible solutions, plus individual presentations of recent innovations in the field of medicine and nursing.
    - b. By scheduling field trips to other counties participating in the Project.

SANITATION

The sanitation service given to migrants is a complete environmental health program. This includes the planning, inspection, enforcement, and evaluation of all services covered by Chapter 170C, Sanitary Code of Florida, with these exceptions: (170C-3) (170C-19) (170C-20) (170C-21) (170C-22) (170C-29). County building and zoning regulations are also enforced.

The entire staff of the Environmental Health Section works on the project. They include: Sanitation Director I, Senior Sanitarian, Sanitarian, Sanitarian Trainee (2), and Clerk-Typist II. (One Sanitarian terminated on March 1, 1968, and one Sanitarian Trainee was employed February 19, 1968.)

Sanitation Director I	Part-Time	All Year	22%
Senior Sanitarian	Part-Time	All Year	14%
Sanitarian (retired 3/1/68)	Full-Time	10 Mos.	85%
Sanitarian Trainee (5 mos.) Sanitarian (7 mos.)	Part-Time	All Year	1%
Sanitarian Trainee (11 mos.) Sanitarian (1 mo.)	Full-Time	All Year	100%
Sanitarian Trainee	Part-Time	11 Mos.	10%
Clerk-Typist II (resigned 3/15/68)	Part-Time	10½ Mos.	20%
Clerk-Typist II (emp. 3/4/68)	Part-Time	2 Mos.	30%
Sanitarian Trainee (emp. 2/19/68)	Full-Time	2½ Mos.	100%

The specific objectives of this program are:

1. To have every camp in Collier County permitted.
2. To increase sanitarians knowledge of the Migrant Health Program.
3. To appraise and inform the public of the Migrant Health Program.
4. To get potable water to the working environment.
5. To upgrade the substandard housing.
6. To require all new permanent camps to have inside sanitary facilities, cooking facilities, and refrigeration.

The continuing education program in basic sanitation is progressing. We feel that we are moving forward toward a final goal of better sanitation. In the camps we have brought approximately 80 per cent into the permitted class. In private housing, we have no separate records; therefore, no evaluation can be given. Our considered estimate is that we actually do 50 per cent of all the related environmental health work with the exception of field inspections where the percentage is very low.

We have a good rapport with the migrant. Through our continuing inspections we attempt to impress these people with the fact that we are trying to improve their living conditions by helping them to help themselves. Several crew leaders have camps for their labor. Their camps are above the average and they are most cooperative in upgrading their camps.

Our relationship with growers has been excellent. Through our general program of advancing sanitary education, we have endeavored to promote the premise that better sanitation and better housing means better labor. We have kept in constant contact with our County and State Welfare Personnel so that we could cooperate in cases where the need for assistance has arisen. We have worked with our neighboring county health department, both in training and in the exchange of needed information. We checked the water systems of our day care centers.

Our relationship with the Farm Labor Representative for this area has been very satisfactory. We furnished him with copies of our inspection reports on several camps when he has requested them. We have had several conferenced with him to better acquaint him with our program. Our relationship with our County Agent has been excellent. We cooperate in all phases of our statistical research. See Exhitib I, Pages 1 and 2. Our relationship with the Farmers Home Administration has been limited. Our most modern camp was financed by F.H.A., as is the Immokalee Water System.

The majority of our work in planning with all of these groups has consisted of an attempt to upgrade the sanitary situation in these camps and work to do away with safety hazards at the camps and in the fields.

We have received consultation from our Regional Consultant. His work has been invaluable as he has been able to give us the benefit of his long experience in Collier County and in the field of sanitation. We also received consultation from our Regional Engineer, and his staff; as necessary.

We need a set of guidelines for evaluation of our work. A complete evaluation of the program by a competent agency from outside the county is needed. Continuous legal advice on a retainer basis is necessary to aid enforcement. Public Health Educators are needed on a daily basis. We also need conversational Spanish lessons for our staff. Correlation of the project report forms with Florida State Board of Health records is needed.

It is our opinion that the migrants are trying to get into private homes rather than stay in the camps. One reason that our camp population is growing is that the total population of the migrants is growing at a rapid rate. The majority of our new buildings are in family units and of CBS construction or modern trailers. The housing is frame or CBS construction. We do not have any tents in the county at this time. Housing is in various stages of condition - from excellent to very poor. We are continually urging the owners to repair or rebuild. We have served legal notices and have taken court action.

We use the Florida State Sanitary Code, Chapter 381 of the Florida Statutes and the Collier County Building and Zoning Regulations. A labor camp is defined by our code as one or more structures housing fifteen or more people, including children. The definition of a camp on the instructions for this report does not exclude the camps which house less than 15 persons. We use the state definition so that we can limit the number of our camps and not include every house occupied by a migrant in the county.

We feel the improvements in the housing are basically due to a demand for better labor and is an endeavor to attract this better grade of labor, the competition for labor which is apparently in short supply, the increased length of stay of the migrant, the program with the Farm Labor Representatives, the availability of legal assistance to the migrant, assistance from County Commissioners, and the Judicial Branch; increased publicity and meetings sponsored by Governor Kirk.

Some of the reasons for unsatisfactory progress are:

1. Continuous, rapid turnover of health department personnel. It is difficult to attract qualified personnel due to the short-term nature of project appropriations.

2. Limited funds sometimes available to growers due to competition and the market situation.

3. Limited operating budget for the health department and related agencies.

4. The splintering of programs by appropriations to direct funded and other non-health oriented groups are further reasons for unsatisfactory progress.

Table "A" has no provision for the capacity of unpermitted camps or private housing.

There are 27 unpermitted camps in the county. These migrants are carried under urban or other locations in this report.

Due to a lack of personnel we are unable to effectively enforce all the regulations. No camp is permitted to operate in this county which does not have running water and electricity. All water systems are pressure type and no pitcher pump or gravity systems are tolerated. All permitted camps have potable water. Arrangements are supposed to be made to dispose of garbage by all camp operators. Tight fitting lids are required.

Sewage is by extended aeration, sand filter, septic tanks, modern portable privies, or pit-type privies built according to the Sanitary Code. Some pit privies are not properly maintained. Eight camps have secondary sewage treatment, two have approved privies and the remainder have spetic tanks. Building permits are required as well as zoning approval for camp locations.

Where central messes are in the camp, we require the same standards set up by Chapter 170C-16 of the Sanitary Code. The food handling practices in these camps are generally good and we have enjoyed a good working relationship with all concerned.

Some of our camps hire professional exterminators to set up their programs of insect and rodent control. Others have their own methods such as spraying and trapping. Getting to and keeping these camps clean is a time consuming task. It uses a good bit of our total effort and patience. We feel that we have made some progress in this area.

Our knowledge of the working environment is limited. It is hard to maintain inspections on fields with our staff. Drinking water is hauled to the field in coolers. They continue to use common drinking cups. Many workers drink bottled soda-pop. Hand washing in the field is limited to ditch water in some cases, but in others the farmers have shallow or flowing wells in the field. Portable privies are furnished for each sex at a few locations. Food is brought in by caterers, we maintain a continuing inspection of these. Also food is brought in by box or bag lunches, and lunches from home.

All of our efforts are health education oriented, although we do not have any formal plan. We sorely need a full-time health educator as the sanitarians and nurses do not have time to carry on a health education program properly. Our newest sanitarian speaks Spanish which does help.

All camps now have approved water supply under pressure, electric power, sanitary privies or flush toilets, and showers. All camps without these requirements are closed or a deadline is set for evacuation. Additional sanitary, fireproof buildings are badly needed in Immokalee.

Improvements have been made in many buildings. Virtually, all have running water in all units. The majority of the rooms are freshly painted. Some improvements are noted as far as outside premises go, but much more needs to be done. Garbage remains a problem, as does maintenance of community bath houses. We do not permit such facilities for new permanent buildings. All new, permanent buildings have inside toilets, showers, hot water, cooking, and refrigeration.

We will continue the improvement of migrant health through a general environmental health program. Continued improvement of water supplies, sewage disposal systems, garbage disposal and general sanitation is expected. We must provide additional inspection of schools, day care centers, restaurants, juke joints, groceries, and other migrant-oriented establishments. We need many additional inspections of food processing and packing houses and food production areas.

New construction in Immokalee was at a low ebb during the past year because mortgage money was not available. The overall progress in the county was of great importance as several fully improved camps replaced substandard ones. We need to increase the number of field inspections, and provide incentive for use of additional state licensed and services portable privies in both temporary camps and field locations.

A public water supply is under construction in Immokalee which will replace individual wells and assure potable water for a majority of the migrant housing. In all, it is felt that the evaluation of migrant labor camp work in this area cannot be realistic without recognition of these factors.

Looking into plans for 1968-69 there are a number of matters which concern the health department staff greatly. Health education, and for that matter, basic education, is an absolute must to bring about a decent way of life. The sanitarian cannot go from door-to-door and talk to everybody. Other agencies exist to do this, aided and abetted by a responsible public. Education must be carried to the migrants.

It is the thought of this health department that registration of all crew leaders must be effected. That such leaders, augmented by growers and members of regulatory agencies, must form an organization to solve the problems in fields and camps. Without joint efforts, we shall not be able to follow through on such endeavors. Migrants must participate in solving their own problems, We will continue to provide orientation and training to migrant personnel from counties, state, Federal, and international programs. We will continue to provide these and other visiting firemen with lists of migrant labor camps and location maps of same, as well as related information and escorted tours. We will continue to participate in the expanding and important self-help housing program which, in effect, accomplishes the goals of the entire migrant project by changing the migrant to a tax-paying, property owning, voting citizen.

The migrant environmental health program cannot be expanded without additional personnel. We would need at least two sanitarians and three sanitarian aides to do a 100 per cent program. Since the 1969 budget will apparently remain the same as this year, expansion of the project is impossible. The addition of health education personnel is in the same cagegory.

Persons who attended the Eastern States Migrant Meeting in Orlando in April, 1968, seemed to agree that this project was probably short lived and would be phased out in a couple of years. Our plans are to absorb the migrant staff into our regular staff and continue the struggle.

OFFICES:
COLLIER COUNTY GOVERNMENT CENTER, NAPLES
IMMOKALEE STATE FARMERS MARKET

PHONES:
NAPLES MIDWAY 9-1953
MIDWAY 9-1954
MIDWAY 9-1955
IMMOKALEE OLDFIELD 7-3306

Collier County Agricultural Department

COOPERATIVE EXTENSION WORK IN AGRICULTURE AND HOME ECONOMICS
STATE OF FLORIDA

NAPLES, FLORIDA
33940

Don Lander, County Agent
Ruth Kinney, Secretary

Dallas Townsend, Asst. Agent
Jim Curtis, Asst. Agent
Barbara Westberry, Lab. Tech.

INFORMATION FOR COLLIER COUNTY
ANNUAL MIGRANT REPORT

Agriculture, the leading industry in Collier County is very dependent on Migrant labor to help produce and harvest its crops. Fall planting is started around the first of August with harvesting beginning the middle of October. From then until the last of May a large labor force is needed. There is usually a slack period from the middle of January until the latter part of February. Some harvesting is carried on during this slack period unless adverse weather conditions cause serious losses.

Collier County must compete with the citrus industry and other vegetable production areas in the labor market for Migrant workers. This competition includes wages, child care, schools, health and most important, living conditions. Agriculture feels that the Collier County Health Department along with its related agencies have improved conditions so as to make this a desirable place for Migrant workers.

Following is a brief table on the growth of agriculture in this county.

1946-47	866 Acres
1950-51	2,232 Acres
1960-61	15,000 Acres

Following is 1966-67 Season

Tomatoes	11,000 Acres
Peppers	4,500 Acres
Cucumbers	3,500 Acres
Melons	5,000 Acres
Potatoes	1,500 Acres
Squash	1,000 Acres
Glads	1,500 Acres
Corn	500 Acres
Citrus	6,000 Acres
Miscellaneous	500 Acres
TOTAL	35,000 Acres

(Exhibit I - Page 1)

Mechanical harvesting, though a reality is still somewhere in the future. Very little produce is planted for processing. Our trade is a fresh market where quality is a premium and this does not adapt itself to mechanical harvesting.

The long range report for agriculture in this county is tremendous. The recently completed DARE REPORT (Developing Agriculture Resources Effectively), indicated by 1975 this acreage will be doubled. This certainly will increase the need for Migrant workers.

Donald W. Lander

DWL/rek

Don W. Lander, County Agent
Collier County

(Exhibit I - Page 2)

STATE OF FLORIDA

OFFICE OF GOVERNOR CLAUDE R. KIRK, JR.

January 18, 1968

Robert R. Wheeler, R. S.
Director
Environmental Health Section
Collier County Health Department
Post Office Box 925
Immokalee, Florida

Dear Mr. Wheeler:

Thank you for a most interesting and informative tour during my recent visit to Immokalee. Many undesirable conditions still exist within the realm of migrant living conditions; however, much progress is evident over the past several years.

You and your staff are doing a tremendous job of helping and improving health conditions for migrant and seasonal farm workers.

There is much to be done in the field of health and I hope you will continue to provide the leadership that you have shown in the past.

Sincerely,

Governor

CRK/ebm

(Exhibit II)

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PART I. GENERAL PROJECT INFORMATION

5. Population data

d. We estimate in computing the migrant population that for every student we have in school (approximately 2,465) we have seven people who are either pre-school or post school age who either work in the fields or stay home to watch children. Therefore, we project our total figure of this group to 19,720.

As we know there are also many migrant adults in this county who have no school ties or connections (single men and women or married couples whose families are either pre-or post-school age) we assume this group would constitute an addition of 20 per cent of our total migrant population. On this basis, the population will equal 19,720 plus 4,930 to give us a total of 24,650. Assuming a 10 per cent error, an adjustment to 22,000 would be a fairly accurate estimate of the migrant population in the county as defined by Florida law.

(Exhibit III)

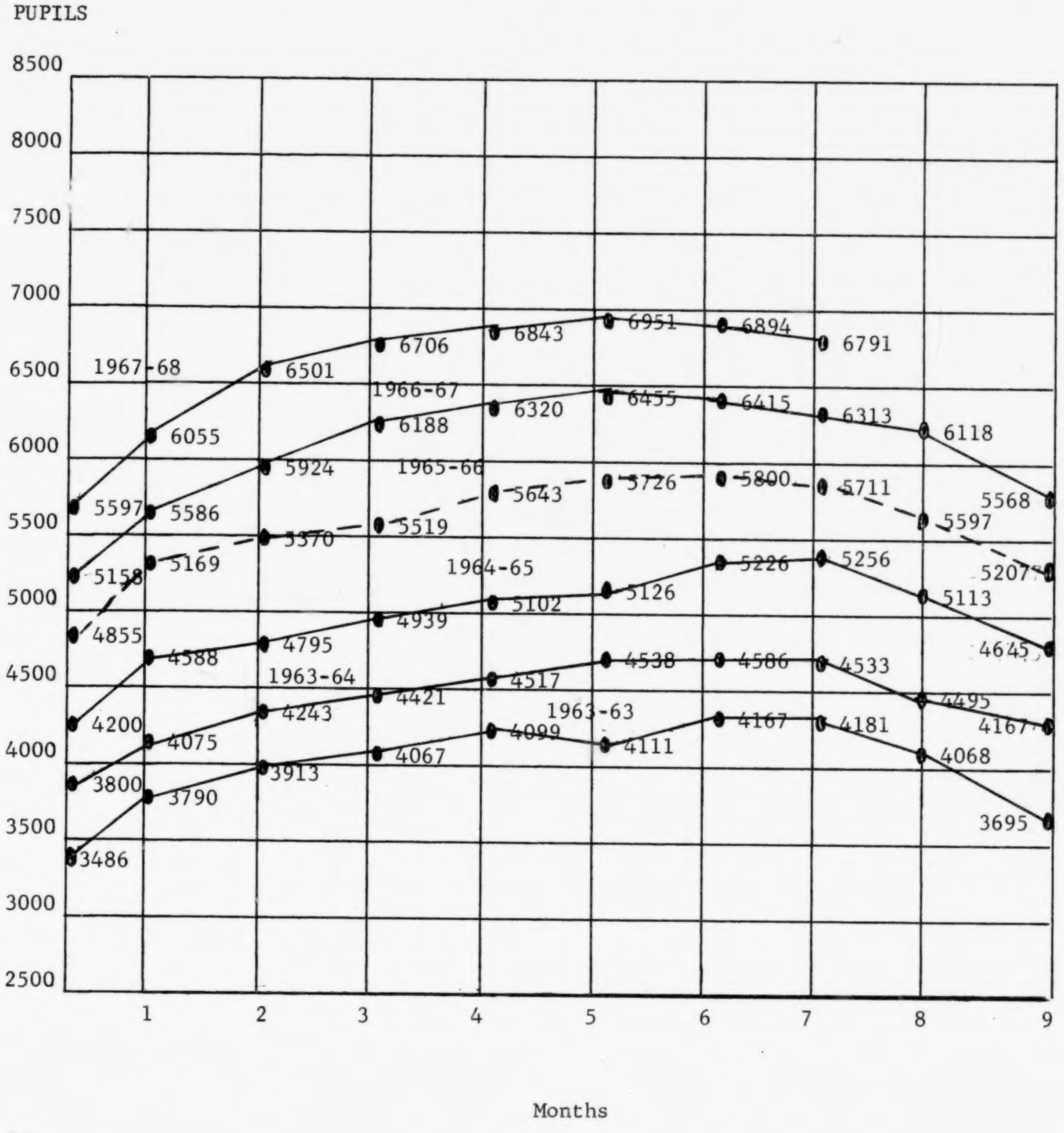
COLLIER COUNTY SCHOOLS

SCHOOL	TOTAL SCHOOL MEMBERSHIP APRIL, 1968	TOTAL MIGRATORY RECORDS COMPLETED MAY 5, 1968
Pinecrest	217	246
Highlands	651	594
Lake Trafford	457	415
Bethune	158	132
Immokalee High	742	480
Everglades Elementary and High	376	85
T. Barfield	59	0
Lake Park	721	37
Sea Gate	580	45
Shadowlawn	909	45
Naples Jr. High	984	44
Carver	117	54
Naples Senior High	761	38
Exceptional	59	0
	6,791	2,215

Total pupil migrant population-------------2,465
Total migratory pupil transfer
forms completed-------------------------2,215
Migratory pupil transfer forms
to be completed---------------------------250

(Exhibit IV)

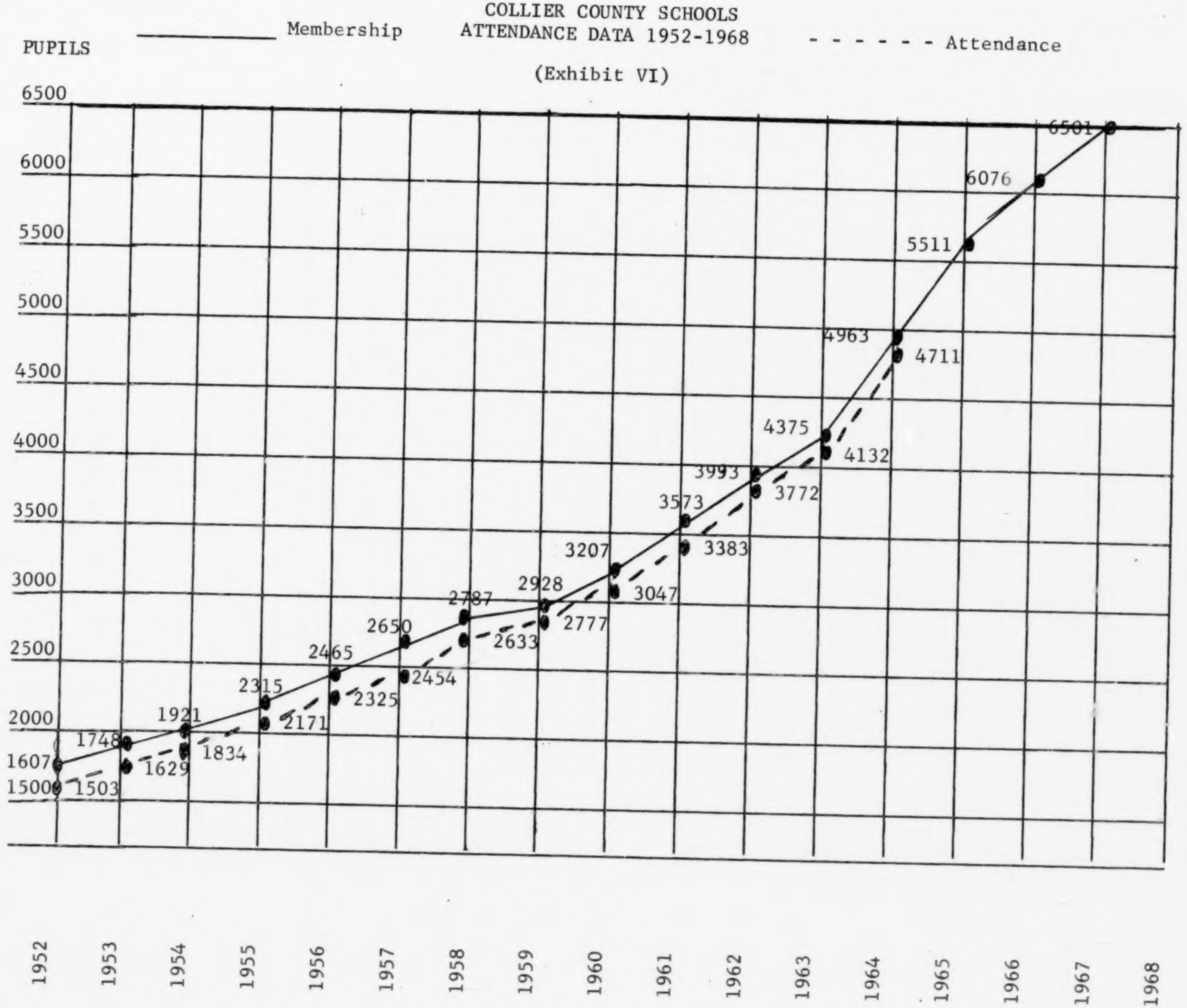
COLLIER COUNTY SCHOOL MEMBERSHIP



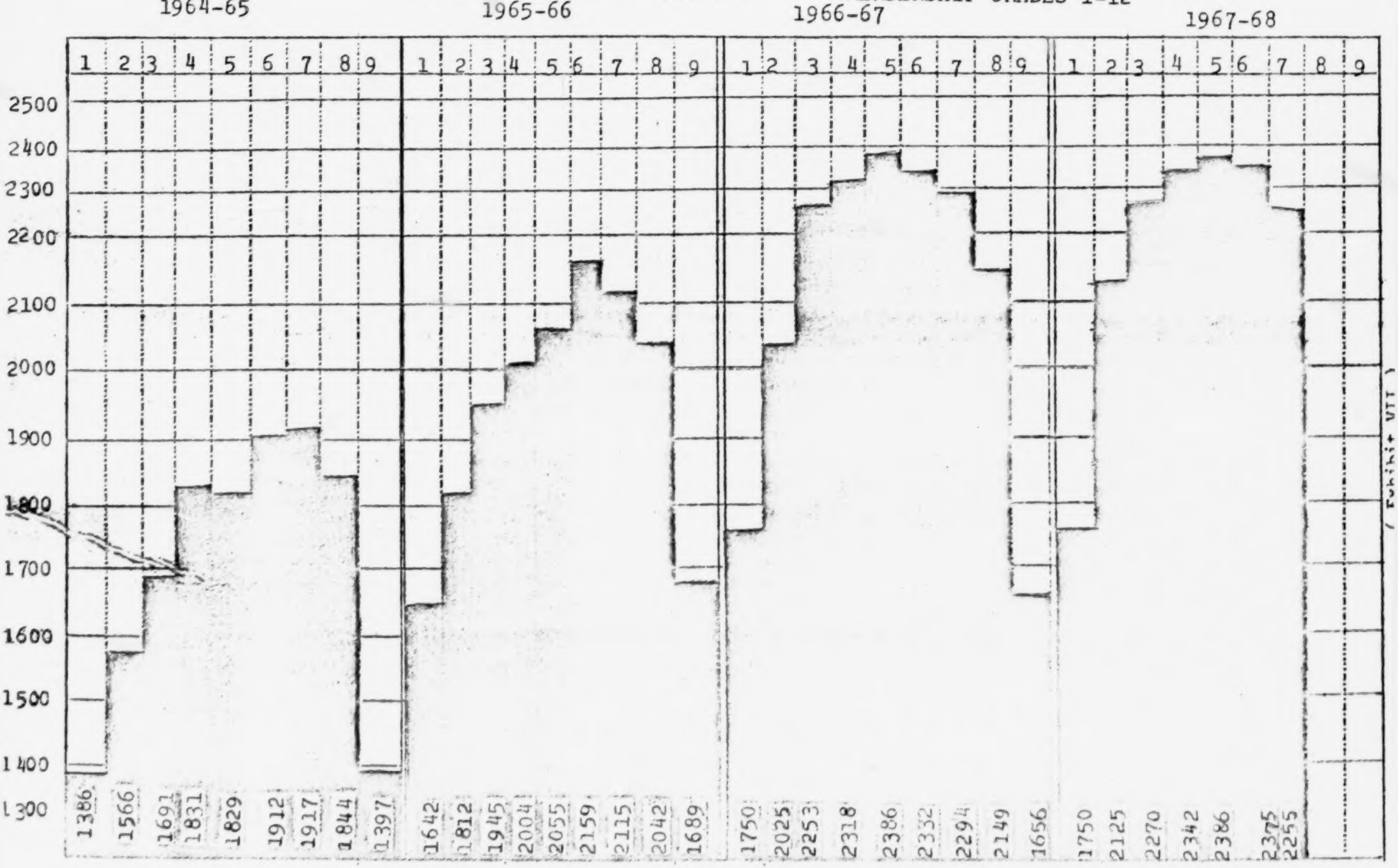
(Exhibit V)

COLLIER COUNTY SCHOOLS
ATTENDANCE DATA 1952-1968

(Exhibit VI)



IMMOKALEE AREA MEMBERSHIP GRADES 1-12



(Exhibit VII)

STUDENT ENROLLMENT SURVEY EFFECTIVE APRIL 1, 1967

(LOW-INCOME)
COLLIER COUNTY

(Exhibit VIII)

School		Number of Low-Income Below $3,000 (Not migrant or seasonal worker	Migrant	Seasonal Worker	GRAND TOTAL
Naples Sr. High	10-12	15	34	7	56
Naples Jr. High	7- 9	140	17	0	157
Lake Park Elem	1- 6	41	41	4	86
Shadowlawn Elem.	1- 6	35	73	8	116
Sea Gate Elem.	1- 6	0	34	4	38
Carver	1- 6	47	0	16	63
Immokalee High	6-12	0	145	102	247
Highlands Elem.	1- 5	91	658	301	1,050
Immokalee Elem.	1- 5	155	182	0	337
Pinecrest	1- 3	4	85	104	193
Bethune	4- 9	36	16	266	318
Everglades (Includes all Everglades & Marco	1- 6 1-12 1- 6	128	13	0	141
TOTAL		692	1,298	812	2,802

Month 3 Ending: November 30, 1967

1967-1968

MEMBERSHIP

(Exhibit IX)

	1	2	3	4	5	6	1-6	7	8	9	7-9	10	11	12	10-12	1-12	% of Att.	Inst.* Persnl.
Naples Senior												269	294	223	786	786	93.3%	37
Naples Junior								312	345	313	970					970	95.0%	43
Lake Park	89	95	141	131	101	119	681									681	96.0%	31
Shadowlawn	191	170	144	130	123	117	875									875	94.8%	35½
Sea Gate	99	87	99	99	97	92	573									573	96.2%	27
Carver	32	29	12	20	8	14	115									115	96.8%	6
T. Barfield	6	8	14	6	10	15	59									59	96.1%	3
Everglades	48	43	29	32	35	28	215	24	17	31	72	26	22	14	62	349	95.2%	22
Immokalee High						154	154	169	138	115	422	85	68	57	210	786	94.2	30
Highlands	134	144	119	136	107		640									640	93.2%	29
Lake Trafford	93	93	93	83	76		438									438	93.6%	25
Bethune				38	29	35	102	23	24	19	66					168	97.5%	14
Pinecrest	72	82	66				220									220	95.0%	8
Exceptional	2	2	16	13	10	3	46									46	93.3%	4
Totals	766	753	733	693	596	577	4118	528	524	478	1530	380	384	294	1058	6706	94.6%	314

EXCEPTIONAL	1	2	3	4	5	6	1-6	1-12
Lake Park			5	2	4	3	14	14
Shadowlawn	1		9	3	1		14	14
Highlands-L. Trafford	1	2	2	8	5		18	18
Totals	2	2	16	13	10	3	46	46

(*) Instructional Personnel - Includes Principals, Librarians, Counselors and Special Area Teachers such as Art, Reading, Spanish, Music, Physical Education, and Exceptional Children. County-wide Instructional Personnel are not included.

September, 1967

Collier County Board of Public Instruction
Naples, Florida

APPLICATION FOR PROGRAM GRANT
Educational Programs for Migratory Children
Title I, ESEA Amendments of 1966 (P.L. 89-750)

PART I. STATUS OF MIGRATORY CHILDREN AND PROPOSED TITLE I PROGRAM

1. Identification of Geographic Area:

Collier County, Florida

School districts in which a substantial number of migratory children live at some time during the year.

	Grades
Naples Area (1)	
Lake Park Elementary	1- 6
Sea Gate Elementary	1- 6
*Shadowlawn Elementary	1- 6
Naples Junior High	7- 9
Naples Senior High	10-12
*Carver High	1- 6
Immokalee Area (2)	
*Pinecrest Elementary	1- 3
*Highlands Elementary	1- 5
*Lake Trafford Elementary	1- 5
*Bethune	4- 9
*Immokalee High	6-12
Everglades Area (3)	
Dupont Elementary	1- 6
Tommie Barfield Elementary	1- 6
Everglades Elementary & High	1-12

*Schools with heaviest concentration of migrant children.

PART I. (Continued)

2. Data on Migratory Children by Geographical Area:

a. Collier County Board of Public Instruction; Naples, Florida.

b. & c. Estimated total number of migrant children moving into this area during the year, including both intra- and interstate children.

	Elementary	Secondary	Total
(1) Naples Area	197	45	242
(2) Immokalee Area	1,792	418	2,210
(3) Everglades Area	13	0	13
	2,002	463	2,465

The above figures do not include an estimated 530 migrant children of pre-kindergarten and kindergarten age which the communities can serve in no way except some token assistance from civic and charity groups.

In the Immokalee area during the peak of the migrant season, school enrollment is easily doubled. It must also be admitted that many of the school-age children who are eligible to attend school do not do so, and it is not unusual for parents to hide their children from school and welfare people to assist at home and work. Few migrant youth beyond sixteen attend school, dropping out as soon as possible and many dropping out at an illegal age.

d. The home base states of these migrant families are mainly:

Texas
Arkansas
Louisiana
Mississippi
Alabama
Missouri
South Carolina
Puerto Rico

An increasing number are considering Florida their home base, and we should add that the Immokalee area is attracting many of them.

The migrant stream scatters, some going up the eastern seaboard ending up in northern New York and the New England states. Some go to Alabama, Georgia, Louisiana, and up the Mississippi Valley to Illinois, Indiana, Michigan, and Wisconsin. Others go to Texas to pick cotton, to Colorado to pick beets, and Idaho for the potato harvest. They follow the season and the crops.

e. Since Florida has a predominantly winter pattern of agriculture, the majority of these transient workers begin arriving in October and usually stay until May. The peak employment is reached in February and extends into mid-April. Most of Collier County's crops are classified as "high labor requirements crops" which do not lend themselves to mechanized harvest operations.

It is not unusual for the enrollment of a school to increase 100 per cent during the peak of the harvest season. During this period, the schoolage migrant children may account for as high as 50 per cent of the school population in our Immokalee area.

The first five months of the school year are marked by heavy pupil enrollments. After January, the enrollments continue at a diminishing rate. The withdrawal of migrant children takes place continuously during every month of the school year, many leaving without any notification to the school. Many of the children enroll in our schools without having been previously enrolled in any other system during the current term.

f. General description of the special educational needs of these children:

In the past, migrant children have received only a fragmented education. Schools face serious problems when migrant children inundate a school. There is a shortage of space and teachers. The teacher is faced with a problem of placement, and usually the migrant child has few, if any, records of previous school experiences. The erratic attendance of the children imposes the extra burden of enforcing school attendance laws.

Moving from one community to another, the migrant child makes few friends outside of his cultural environment and forms no permanent ties to school, teachers, or classmates. Continuously interrupted studies negate achievement and build barriers to the development of self-confidence and self-respect. Without special help, the migrant child can never hope to keep up with his age peers, and each year of accumulating retardation carries with it a growing indifference to learning.

Because of his continuous mobility, the migrant child is usually retarded in grade achievement from two to three years. He is frequently handicapped by his bicultural background. Since has has seldom experienced a sense of achievement, he suffers from insecurity and anonymity. He requires special attention from an already overworked teacher, who frequently lacks the experience and understanding to deal with problems associated with cultural deprivation.

PATIENT TRANSPORTATION FOR MEDICAL SERVICE

Transportation furnished by Migrant Health Project Ford Falcon bus and operator to Physicians outside of Collier County. Miami area 171 trips averaging 250 miles per trip. Six trips to Tuberculosis Hospital in Lantana, round trip, 300 miles. Twelve trips to Naples from Immokalee, averaging 90 miles per trip. Outline of trip by services as follows:

	Children	Adult
Anti-Convulsive Clinic		
Jackson Memorial Hospital, Miami	33	4
Cancer Clinic		
Miami Beach	8	400
Crippled Children's Clinic		
Miami	125	0
Council for the Blind		
Miami	46	33
Out-Patient Clinic		
Children's Variety Hospital, Miami	10	0
Cardiac Hospital		
Miami	1	0
Vocational Rehabilitation (Medical)		
Miami	0	25
U.S. Veterans Administration Hospital		
Miami	0	9
Tuberculosis Hospital		
Lantana	0	9
Total: 703	223	480

To Naples area - total of 46 patients; all adults:

Dentist	9
Psychiatrist	1
Chest X-ray	23
Private Physicians	12
Naples Hospital	1

Volunteer transportation to Naples from Immokalee - all adults, total of six patients:

Dentist	1
Chest X-ray	2
Naples Hospital	1
Private Physician	2

C.A.F. (Community Action Fund) has transported approximately 208 patients from Immokalee to Naples for dentist, private physician, Naples Hospital, and the health department for chest x-rays.

(Exhibit XI)

Nutrition Services

I. General description of services

A. There is one nutritionist assigned part-time to work with migrant farm laborers in Collier County.

Nutrition is an important part of the health education that the public health nurses continually do with patients. Assistance is also given by the two interpreter-aides in the Immokalee clinic, when needed.

B. The primary objective of the nutritionist is to provide nutrition services to the migrant farm laborers in Collier County.

Secondary or contributory objectives would be as follows:

1. To help identify nutrition needs and problems among the migrant farm laborers.

2. To help create among the migrant farm laborers a greater awareness of nutrition as a part of health.

3. To study the use of available nutrition services.

C. The nutritionist works closely with all other personnel in the health department, attempting to meet the needs of the migrant farm laborers. The nutritionist has managed to establish a degree of rapport in working with the people, and has been aided greatly in this respect by the two interpreter-aides working in the Immokalee area.

D. Assistance was obtained as needed from the Division of Nutrition, Florida State Board of Health, and from the Nutrition Coordinator for the state-wide Migrant Health Project.

E. Additional consultation would be unnecessary.

II. Description of services provided to migrants, to other project staff, to growers, and to other community groups.

A. Diet counseling was provided to patients with nutritional problems both in health department clinics and in home visits when requested. Of 171 prenatal patients, 136 patients were counseled on normal nutrition during pregnancy. Problems presented by the other 35 prenatal patients included excessive weight gain, edema, hypertension, anemia and diabetes.

Other problems requiring diet counseling were anemia, diabetes, allergy, weight control, food budgeting, hypertension, infant nutrition, and normal nutrition for adults.

B. At the request of the public health nurse, the film "Safe Food" was shown and discussed with one of the science classes in the Adult Education Program at Bethune High School in Immokalee.

Mothers of Headstart children who were found to be anemic in their physical examinations were counseled on normal nutrition with special emphasis on foods high in iron content.

Basic nutrition using the Basic Four Food Groups as a foundation was discussed with five science classes in the Adult Education program at Bethune High School and with an ungraded class at Pinecrest Elementary School in Immokalee.

Nutrition services to migrant farm laborers were observed in the Immokalee area by a graduate nutrition student from the University of North Carolina as a part of her public health field work experience.

At the request of the Director of the Division of Nutrition, diet histories in health department records in Immokalee were reviewed and evaluated for use in a report of the investigation concerning rumors about malnutrition among the migrants. Pricing was also done in three of the local grocery stores in Immokalee.

III. Appraisal of effectiveness of educational effort.

A. One of the problems encountered in attempting to provide nutrition services to meet the needs of the migrants is the identification of what the needs are. An attempt is being made toward the identification of these needs through the use of diet history form which becomes a part of the patient's health department record. This form includes a 24-hour record of the patient's intake of food. It is beneficial in helping to identify possible deficiencies in the dietary habits of the individual, thus making diet counseling more meaningful.

B. Lack of adequate office space has, at times, been a hindrance in providing nutrition services effectively. The same office is shared by several different agencies and when more than one of them is in the health department at a time, it is difficult for either to interview clients very effectively.

IV. Specific plans for future objectives, procedures, relationships, etc.

A. It is anticipated that future objectives for nutrition services to migrant farm laborers in Collier County will remain the same.

Emphasis may shift from direct services to the migrants to nutrition consultation to health department personnel, but the primary objective would remain that of providing nutrition services to the migrant laborers.

In an effort to reach more migrants, nutrition information will be presented to more groups as well as individual diet counseling.

DENTAL CLINIC

The Collier County Health Department Dental Clinic is primarily a pedodontic clinic. As such, elementary school children comprise the majority of the case load. Approximately 65 per cent of the children are migrants, most of whom come to the clinic from Immokalee. These children are transported each morning, in groups of six or seven, from Bethune, Highlands, Lake Trafford, and Pinecrest Elementary Schools and Immokalee High School. A special bus is furnished by the Collier County School Board.

Treatment is also given to pre-school age migrant children all year round. During the summer months, migrant children are also included in the Headstart Program. This program furnishes the transportation for these children to the clinic.

In all cases, instructions in oral hygiene are stressed.

Emergency care is given to migrant adults when necessary. One afternoon a week is devoted to migrant adults from Immokalee. Their transportation is furnished by the Community Action Program.

DADE COUNTY DEPARTMENT OF PUBLIC HEALTH

William R. Stinger, M. D., Acting Director

Area of County: 2,054 square miles

Resident Population: 1,124,200

Migrant Health Project Staff:

- 1 Public Health Nurse Supervisor
- 4 Public Health Nurse II's
- 1 Public Health Physician
- 1 Project Coordinator
- 1 Health Educator II
- 1 Lab Technician II
- 1 Clerk-Typist II
- 1 Health Field Worker II

PRETEST DRAFT - 1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT
For June 1, 1967 through May 31, 1968
Date submitted June 1968

PART I - GENERAL PROJECT INFORMATION

1. Project Title
Comprehensive Health Care for Migrant Farm Workers in Dade County

2. Grant Number (use number shown on approved application)
MG-34 D (67-68)

3. Name and Address of Applicant Organization
Dade County Department of Public Health
1350 N.W. 14th Street
Miami, Florida 33125

4. Project Director
Hunter B. Rogers, M.D. Director
Division of Adult Health & Aging

5. Population Data - Number of Migrants (workers & dependents) for Dade County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	Not recorded.		
Under 1 year			
1 - 4 years	Eligible for		
5 - 14 years	county & state care		
15 - 44 years			
45 - 64 years			
65 and older			
2. In-migrants			
Total			
Under 1 year	402	NO	Breakdown
1 - 4 years	1326	"	"
5 - 14 years	2836	1342	1494
15 - 44 years	6250	4076	2174
45 - 64 years	1296	802	494
65 and older			

b. Number of migrants by month:

Month	Total	Month	Total
1968 Jan.		1967 Jul.	
Feb.	12110	Aug.	
Mar.		Sep.	
Apr.	6300	Oct.	
May		Nov.	
June		Dec.	9486

c. Average stay of migrants in county:
Out-migrants: Not recorded weeks
from ________ (mo.) through ________ (mo.)
In-Migrants: 14 weeks
from Dec. (mo.) through March (mo.)

d. Source of information and/or basis of estimates: Camps Census - Door to Door
Outside Camps: Few State Emp. Serv.
Schools & Other agencies

6. Housing accommodations for DADE County:

a. Camps

Maximum Capacity	Number	Occupancy (peak)
Less than 10 persons		
10 - 25 persons	2	47
26 - 50 persons	5	177
51 - 100 persons	7	727
More than 100 persons	8	4809
Total	22	5760

b. Other housing accommodations

Type	Number	Occupancy (peak)
Farms		
Other locations	*	7,000 to 8,000

Private (public) housing under supv.
Fla. Hotel & Rest.Com. and County Min.
Housing Auth.

c. Append map showing location of camps, roads, clinics, and other places important to project.

SEE TABLE B

RECAP.PAGE # 1

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Project No. MC-34 D (67-68)
Date submitted June 1968
DADE COUNTY

PART II - MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of Visits
	Total	Male	Female	
Total	3172	3124	3071	6195
Under 1 year	182	Visits		374
1 - 4 years	450			908
5 - 14 years	501			886
15 - 44 years	2010			2866
45 - 64 years				1047
65 and older	29			114

* See Note

2. Patients hospitalized:

132

Age	Number of patients			Hosp. Days
	Total	Male	Female	
Total	132	89	43	1370
Under 1 year	24	16	8	207
1 - 4 years	2	1	1	35
5 - 14 years	6	4	2	101
15 - 44 years	75	47	28	667
45 - 64 years	25	21	4	360
65 and older	0	0	0	

3. Patients receiving dental services:

Item	Total	Under 15	15 and Older
a. Number of migrants examined: total	203	11	192
Number of decayed, missing, filled teeth			
Average DMF per person			
b. Individuals requiring services: total	203	11	192
Cases completed			
Cases partially completed	(Broken	Appointments	150)
Cases not started			
c. Services provided: total			
Preventive			
Corrective	203	11	192
Extraction			
Other	154	9	145
d. Patient visits: total	59	2	57
	203	11	192

4. Immunizations provided:

Type	Incomplete series	Completed immunizations - by age					Boosters, revaccinations
		Total	Under 1 year	1 - 4	5 - 14	15 and older	
All types	369	516	9	265	158	13	71
Smallpox	34	89	0	33	52		4
Diptheria	86	98	2	39	33		24
Pertussis	86	67	2	39	14		12
Tetanus	80	120	2	45	37	13	23
Polio	83	72	3	43	18		8
Typhoid							
Measles		68	0	66	4	0	0
Other (specify)							

* In addition to the above, Migrants have made:

Visits to Maternity & Family Planning Clinics . . . . (200 were new prenatals and 147 new Family Plan. visits)	1,033
Visits to Child Health Supervision	434
School physicals by MPH clinic physician	144

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DADE COUNTY

5. Medical conditions found by physicians among outpatients, by age of patient:

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
I	Infective and parasitic dis.	510		82	114	236	72	6
	Tuberculosis	12				8	4	
	Venereal Disease	152				135	17	
	Measles	62		25	37			
	Infestation with worms	91		40	35	16		
	Dermatophytosis & other infections of skin	183		17	35	75	50	6
	Other	10			7	2	1	
II	Neoplasms	5			1	3	1	
	Malignant							
	Benign & unspecified	5			1	3	1	
III	Allergic, endocrine, metabolic, and nutritional dis.	177	4	9	10	78	68	8
	Diabetes	94				30	58	6
	Malnutrition	53	2	8	10	23	8	2
	Other	30	2	1		25	2	
IV	Dis. of blood and blood-forming organs	158	1	5	22	90	31	9
	Anemias	158	1	5	22	90	31	9
	Other							
V	Mental, psychoneurotic and personality disorders	96			7	53	35	1
VI	Dis. of nervous system and sense organs	272	36	71	77	62	20	6
	Cerebro-vascular disease (stroke)							
	Eye Diseases	151	20	35	45	30	15	6
	Dis. ear and mastoid pro.	115	16	35	31	30	3	
	Other dis. of nervous system	6		1	1	2	2	
VII	Dis. of circulatory system	217		2	4	72	127	12
	Rheumatic fever	2				2		
	Diseases of the heart	22		2	3	10	6	1
	Hypertension & other dis. circulatory system	193			1	60	121	11
VIII	Dis. of respiratory system	1514	192	386	221	499	186	30
	Upper respiratory	1038	151	303	141	328	95	20
	Influenza and pneumonia	79	5	9	21	23	19	2
	Bronchitis	280	35	60	39	96	45	5
	Other	117	1	14	20	52	27	3

5. Medical conditions found by physicians among outpatients, by age of patient (cont'd.):

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
IX	Digestive system diseases	868	105	219	83	313	105	43
	Teeth and supporting structures	182	7	12	20	102	40	1
	Gastroenteritis, colitis	649	95	199	58	192	63	42
	Other	37	3	8	5	19	2	
X	Dis. of genito-urinary system	164	2	3	12	127	14	6
	Urinary system diseases	86	2	3	5	59	11	6
	Genital system diseases	78			7	68	3	
XI	Deliveries and complications of pregnancy							
	Complications of pregnancy							
	Deliveries							
	Compli. of puerperium							
XII	Skin diseases	381	7	101	127	125	17	4
	Impetigo	220	5	80	96	35	4	
	Other	161	2	21	31	90	13	4
XIII	Dis. of bones and organs of movement	169		1	5	80	63	20
XIV	Congenital malformations							
XV	Dis. of early infancy							
XVI	Symptoms, ill-defined cond.	69	1	2	19	40	4	3
XVII	Accidents, poisonings, violence	246	10	21	35	125	51	4
	TOTAL OF CATEGORIES I-XVII	4846	358	902	737	1903	794	152
	*	1243	88	147	121	686	197	7
SUPP	Special conditions, examinations, w/o sickness: total	183	12	26	22	117	6	
	Prenatal, postnatal care	56			2	53	1	
	Physical examinations	3			3			
	Immunizations	60	11	26	15	6	2	
	Surgical or medical after-care, follow-up	12			2	7	3	
	Fitting prosthetic devices							
	Other	5	1			4		
	Family Planning **	47				47		

* These patients were seen at: Kendall Clinic (County), Jackson Memorial Hospital, and James Archer Smith Hospital (Homestead). They were not recorded by diseases for the 1967-68 season but will be so recorded starting with the 1968-69 season.

NOTE: There are more Medical conditions than visits.

** To initiate Family Planning the women are urged to first visit a F/P clinic at one of our health centers. See note under Part II-1 (1,033 visits).

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Date submitted June 1968

DADE COUNTY

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number
a. Visits to homes	2908
b. Total households served	1027
c. Visits to schools, day care centers: total	128
d. Migrants presenting health record on request (PHS 3652)	15
e. Migrants given health record	253

Services provided:	Number
f. Health supervision, counselling, teaching, demonstrating care in homes	2908
g. "Sick call" (nursing clinics)	0
h. Referrals for medical or dental care: total	
Within area: total	469
Number completed	317
Out of area: total	97
Number completed	52
i. Other (specify)	

2. Sanitation services

Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	22	22	1360	1360	6,205	** 3	3	381
Urban or * other locations	Under Fla. Hotel & Restaurant Comm. & County Min. Housing Authority							

Table B. Inspection of living and working environment of migrants

	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	22	202	35	35
b. Sewage	22	774	214	214
c. Garbage and refuse	22	774	75	75
d. Housing	22	774	375	375
e. Safety	22	774	10	10
f. Food handling	22	368	43	43
g. Insects and rodents	22	774	4	4
h. Recreational facilities	22	774	1	1
Working environment				
a. Water				
b. Toilet facilities	Field crews (Facilities limited)			35 Chem. toilets
c. Other	Facilities are adequate in the packing houses, and in the canning plants, but very inadequate in the fields.			

* Locations - camps or other locations where migrants work or are housed

* The major urban areas for private housing are located in: Perrine, Goulds, Princeton, and Homestead-Florida City. See Table B (Map)

** This total included in 'Housing Units' total

DADE COUNTY DEPARTMENT OF PUBLIC HEALTH

PART IV. Narrative for Annual Progress Report on Public Health Service Grant MG-34E
Comprehensive Health Care for Migrant Farm Workers in Dade County (68)

A. This report covers twelve months; beginning June 1, 1967, and it is the fifth such report since this project began on January 1, 1964. The Migrant Health Branch of the United States Public Health Service continued the project on January 1, 1968.

B. The primary objective of this project is to provide a comprehensive and coordinated program of clinical, nursing, and sanitation services to migrant farm workers and their dependents in Dade County.

Contributory and secondary objectives include the following:

1. Determination of the health needs of agricultural migrants in this area.

2. Meeting these needs with existing community resources when possible, and filling some of the remaining unmet needs through services provided by this project.

3. Identification of other factors which affect health services for agricultural migrant workers in Dade County.

4. Establishment of standardized records and procedures to facilitate follow-up care through improved interstate and intrastate cooperation and communication.

5. Publication of results which may be deemed useful elsewhere.

6. Affording training opportunities for persons interested in the development of similar activities in other states.

C. No basic changes in our objectives are planned for the 1968-69 season. The need continued for an increase of funds for inpatient care.

D. Significant changes in migrant situation from previous year.

1. The camp census at peak occupancy was about 900 over last season. At this period there was a noticeable drop in total American Whites and Puerto Ricans. On the other hand, there may have been an equivalent increase of these ethnic groups in private housing.

2. There were no dramatic changes in the economic situation.

3. Even though there have been no noticeable changes in clinic proceedings, the general increase of total attendance would indicate that the services offered are getting a wider acceptance. It is believed that these services should be continued on at least the present level. An application for continuation of the project is being prepared.

A. Medical and Dental Services

Family health service field clinics are operated in four locations. Two of these are in large migrant camps and the other two are in areas near large concentrations of migrant housing (See Tables B & C). With the exception of the Perrine Clinic, an afternoon clinic is held in each location. The South Dade Farm Labor Camp Clinic was open two nights each week because of the heavy attendance; the other locations have one night clinic weekly. Immunization clinics were held at the end of the afternoon clinics, two sessions each month.

Comparisons between the 1967-68 family health service clinic caseload and the previous seasons are as follows:

	1967-68	1966-67	1965-66	1964-65
Total Attendance	4,947	3,497	4,557	3,410
Total Clinic Sessions	218	152	268	225

The migrant dental clinic is held two nights each week. This clinic continues to be plagued by broken appointments, but by scheduling more patients than can be conveniently cared for, the dentist is kept busy. The facilities are now shared with the Head Start and Maternity and Infant Care Programs.

The staff of the Migrant Health Project consists of a director, one full-time medical doctor, one part-time dentist, one coordinator, one nursing supervisor, four staff nurses, and a clerk.

B. Hospital Care

In addition to migrant family clinics, the Migrant Health Project has contracts with hospitals to see patients on an outpatient basis. Patients seen in family clinics who are in need of x-ray or more extensive laboratory procedures than we are equipped to do or who require hospitalization are referred to one of these hospitals. One hundred and seventy-six (176) such referrals were made.

C. The Head Start Program will give some service to the migrant children. Maternity and Infant Care Project gives prenatal, postnatal, and infant care to certain migrant families. This includes up to total care for the mother and covers the first year for the infant. Migrant families are referred to this service to start family planning. They are then continued under supervision of the Migrant Health Project physician and nurses in their homes and the project clinics. Total visits may be found on recap. pages #2 and #4. Children and Youth Project covers 99 per cent of the migrant area and includes children for hospital care through the sixth year of age. This service was just getting under way this season.

D. The Migrant Legal Service has been a valuable resource to us this year. They have been of assistance in helping patients get emergency welfare funds, in answering migrant legal questions, and were most valuable in the case of a hydrocephalic infant who needed to be institutionalized. Without their help, this Spanish-speaking family might have found great difficulty in managing the mechanics of a court committment proceeding.

During our busy season, we had two women who each volunteered three hours a week to serve as registrar in a clinic. They are both bilingual, so are of inestimable value to the project. These volunteers gave a total of 87 hours. Other volunteers gave 32 hours for the season. The clerk on the Migrant Health Project serves as registrar at two clinic sessions. The search for volunteers for these clinics continues. The fact that they are night clinics for four rural areas makes this difficult.

The annual x-ray survey was conducted with the mobile unit visiting 22 camps and several communities in South Dade during the 1967-68 season. Three of the ten new cases were found in one family, and one old case discovered. The following table represents a six-year comparison of these surveys:

	1968	1967	1966	1965	1964	1963
No. of x-rays	4,687	3,428	4,415	4,796	4,741	3,447
No. of camps	22	22	23	16	26	32
No. of new T.B. cases discovered	10	3	4	4	5	9

These totals are not reflected in any other part of this report.

NURSING

The nursing staff of the Migrant Health Project consists of a supervisor and four nurses, when all positions are filled. Since March 1, 1968, we have had one vacancy which we have been unable to fill. This staff is supplemented by 18 public health nurses from the generalized program, who devote varying amounts of their time to service to migrant families and to migrant school children. More than 40 home visits were made by a community health worker. These are visits for the purpose of making appointments of follow-up on broken appointments and professional skills did not seem necessary.

Public health nurses made 2,908 home visits to migrants. The largest number, 1,426, was made on behalf of child health supervision.

The next greatest number, 945, was made on behalf of maternity and family planning. Visits on behalf of tuberculosis accounted for 227 of the total, and 280 home visits were made to acutely or chronically ill persons. Many of these were to follow-up persons treated in migrant family clinics. Three of the project nurses are assigned to large labor camps. They also work in the family clinics which serve these camps. This has made for excellent continuity of care.

In addition to home visiting, the public health nurses visit the schools and day care centers regularly where migrant children are enrolled. Problems discovered there are referred to migrant family clinics, regular health department clinics or for follow-up in the home. A program to immunize the children enrolled in day care centers was only partially successful. Attendance in these centers is sporadic and this contributes to the problem.

Each public health nurse acts as a health educator. The health department has several nutritionists and they have been an excellent resource service for them. The position of health educator on the project was deleted so that formal health education has been impossible. In cooperation with the Women's Auxiliary of the Dade County Medical Association, the American Red Cross was interested in teaching a class for "Mother's Helpers" to a group of 8 - 12 year-old children at Redland Labor Camp. This age group was selected because they do much of the child care, and they may soon be parents themselves. This class was a pilot project, and it is hoped that the program can be expanded next season. In addition to this project, the YWCA is interested in a class to reach young prenatals. This class will include hygiene, nutrition, family planning, and many other subjects of interest to the participants. The mechanics of this could not be worked out for this season, but the class will be started in the fall. The project nursing supervisor works with these groups to interest and encourage them and to help them develop materials pertinent to the problems of migrants.

Each year the referral system becomes a bit more effective. This year we were able to complete 52 of 97 referrals received from out of the area. The others could not be located.

Because of its happy ending, we would like to tell of one case in particular:

> Nancy S. was brought to the attention of the Migrant Health Project by a referral from Virginia. The referral stated that Nancy did not talk and was profoundly deaf. On the same day that the public health nurse received the referral and made a home visit, the family sought the health department, asking for help. The University of Miami Otology Clinic was contacted and they agreed to see the child. The normal residence requirement was waived because the hospital involved and the Migrant Health Project have a contract to see patients on an outpatient basis. After the records from Virginia were received, additional tests were made and a hearing aid was prescribed. A training hearing aid was given to the family to teach Nancy to properly wear one. The nurse visited regularly to encourage the family in this training period. During this time, the Dade County School Board's Special Education Department was called, and arrangements were made to enroll the child in a class for the deaf in September, 1968. This could be accomplished only if the child had received her permanent instrument. Because of the high cost of such an instrument, financial help in purchasing one was necessary. The Florida Crippled Children's Commission was enlisted at this point and they agreed to supply the hearing aid. Because of the need for continuous follow-up and supervision for Nancy, the family is not leaving the area this year and are delighted that Nancy will be in school in September. With proper training, it is hoped that Nancy will learn to speak. This has been an especially satisfying case to those who have worked on it because the family has been most cooperative and interested and has never failed to keep an appointment, and because with the cooperation of several agencies, it has been brought to a successful conclusion.

In general, nursing service to this migrant is adequate. The diligence of the nurses, both project and general program, help to make this so. We feel that at least one life was saved by a project nurse being at the right place at the right time:

> The nurse in point is assigned to a large labor camp, and was there when a labor bus arrived from New York. She asked about health problems among the workers and saw one man who was acutely ill. It was the nurse's judgement

that the man required immediate hospitalization, so she referred him at once to Jackson Memorial Hospital. The crew leader was fully cooperative and took the man there. He was admitted with a diagnosis of hypertension, congestive failure. After 24 days, he was discharged to be followed in migrant family clinic for his hypertension and an unhealed leg ulcer. He was seen twice each week. Under therapy, the blood pressure was stabilized and when the patient left the area, about May 1, the leg ulcer was healed. Much time was spent in instructing the patient in diet and hygiene and it is hoped that he will remain well. Index referrals were sent to Virginia and New York to provide continuity of care.

SANITATION

Section I.

A. Sanitation services were provided by one sanitarian on a full-time basis and two sanitarians on a part-time basis during the period covered by this report. No volunteers have been involved thus far and the "project staff" is still unable to initiate a part-time health aide program.

B. The location and population of migrant camps in Dade County is presented in Tables A and B.

C. The Homestead Housing Authorities' efforts to modernize the "Redlands" and "South Dade Labor Camp" have been delayed by the county zoning board's disapproval for this work. The County Commissioners, on hearing the appeal, approved this project. This will have a great impact on the housing of Dade County migrants when completed. To date, the growers have not wholeheartedly initiated the use of chemical toilets for use by crews in the field. In the past, it was hoped that this would be accomplished by education. It would seem that legal action may be necessary to see their general use.

During the past season, a closer cooperation between the health department and the Florida Industrial Commission Farm Labor Office in certification of Migrant Farm Labor Camps has been highly valued.

Periodic visits by the U.S. Public Health Service Regional Migrant Health Representatives have proved helpful in initiating some changes by promoting new ideas.

Section II.

A. Condition of camp housing is considered from acceptable up to very good. All houses must be weather-tite to be approved. Many of these are frame houses with some form of composition siding, such as composition covered paper, composition shingles, weather boarding, and others are cement block. All living units must be within 200 feet of flush toilets, hot and cold water, and facilities for washing clothes. All central facilities are so located that very few living units are as far away as 200 feet. Cold water outlets are available from 5 to 25 feet from each living unit.

B. All applications for permits to operate these camps must be approved by the Florida State Board of Health. It will be noted from past reports that the total number of these camps permitted continue to decrease. There are several factors involved. A major one is the health department's continued pressure on operators to upgrade their facilities. This results in many of the workers being overcrowded in private housing. Private housing is the responsibility of the Florida Hotel and Restaurant Commission and other housing authorities. It would take a very large staff of field workers for the responsible agencies to keep track of this situation. Nevertheless, our sanitarians investigate any sanitation complaint in all areas. Many of these situations in the south part of the county involve migrants, but the department does not tabulate them separately.

A comparison of camp statistics for the last five seasons reveals the following: Note that there is an increase in population, but three less permitted camps.

	1967-68	1966-67	1965-66	1964-65	1963-64
Maximum Census	5,760	4,885	4,741	5,732	6,355
Number of Camps	22	25	26	28	41

The increase of approximately 900 in population over the past two seasons is not considered a change in the trend away from camps.

C.

1. All plumbing facilities are modern pressure-water systems and flush toilets. Two of the larger camps have municipal-type sewage systems. All other camps have septic tanks. Garbage is kept in approved garbage cans and collected two or three times per week. Refrigeration has been a difficult problem due to the unwillingness to share facilities.

2. Food handling practices are from poor to excellent. They are usually good to excellent where there are no family groups, but it is almost impossible to get the family groups to use the facilities, especially provided for the preparation of food. All openings are well screened at the start of the season, but many of the occupants either break the screens out or prop the doors and windows open.

3. As previously stated, there has been a strong educational campaign to convince growers and crew leaders that chemical toilets should be provided conveniently to all crews in the fields. There is still much to be desired in providing handwashing facilities and food handling. We find that an adequate supply of portable water is available to all crews.

Health Education

Individual counselling by all of the public health nurses, sanitarians, and other staff personnel associated with the project continues to be the major educational program. Local O.E.O. and Community Action Program officials, working under the guidance of the director of the health department's health education division, and using films furnished by that division have continued their work along these lines. It is hoped that those viewing the films and hearing the talks will be motivated to improve their personal and community hygiene. Described in more detail in the Nursing Section of this report is the work done by the Women's Auxiliary of the Dade County Medical Association, the American Red Cross, and the Y.W.C.A.

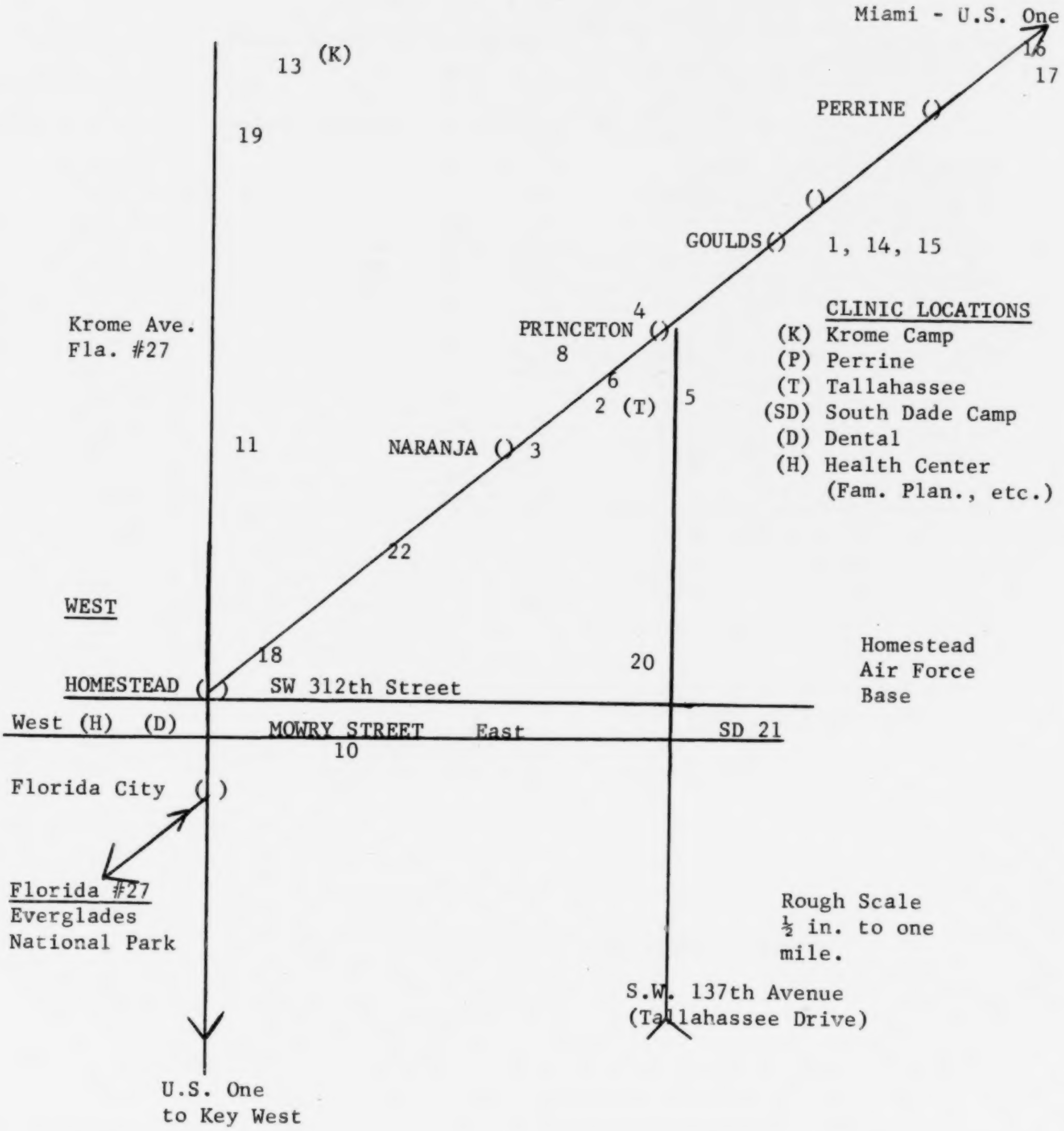
	NAME OF CAMP	POPULATION BY ETHNIC GROUP				TOTAL POPULATION		
		AW	N	M	PR			Auth. Cap.
1.	Bailes Road Labor Camp		16			F	16	41
2.	Borinquen Farm Labor Center				130	B	130	204
3.	Brooks Labor Camp		40			F	40	48
4.	Bull, C.R. Labor Camp	20	375	425	67	B	887	698
5.	Campbell, J.W., Camp East	1	15	285	38	B	339	240
6.	Campbell, J.W., Camp West		315	80		B	395	90
7.	Carpenter's Labor Camp		12	22		B	34	30
8.	Cox, H.L. & Sons Labor Camp		75			B	75	80
9.	Cross, H.D. Farm Labor Camp				48	M	48	37
10.	Douberly, Everett Labor Camp		33			B	33	80
11.	Douberly, Emmett Labor Camp		33			B	33	22
12.	Far South Farm Labor Camp		152			B	152	150
13.	Kettles Labor Camp		66			B	66	60
14.	Krome Avenue Farm Housing Center	14	807	568	1	B	1390	1800
15.	Markham's Farm Labor Camp				36	M	36	80
16.	Pearce Produce Labor Camp #1		24		16	B	40	95
17.	Pearce Produce Labor Camp #2		45			B	45	115
18.	Redland Farm Labor Camp	198		546		F	744	747
19.	Sanders Labor Camp #2		80		2	B	82	76
20.	Shaw, Marvin Labor Camp		14			B	14	12
21.	South Dade Farm Labor Camp		328	794		B	1122	1450
22.	Williams, Dan Farm Labor Camp		2	37		F	39	47
		233	2392	2757	338		5760	6205

ABBREVIATIONS:
AW - American White
N - Negro
M - Mexican
PR - Puerto Rican

M - Indicates housing for men only
F - Indicates housing for families only
B - Indicates housing for both single men and families

Peak Population in Permitted Migrant Camps in Dade County
1967-1968 Farm Season

TABLE A


Miami - U.S. One
16
17
PERRINE ( )
( )
GOULDS ( )
1, 14, 15
13 (K)
19
Krome Ave.
Fla. #27
4
PRINCETON ( )
8
6
2 (T)
5
11
NARANJA ( ) 3
22
CLINIC LOCATIONS
(K) Krome Camp
(P) Perrine
(T) Tallahassee
(SD) South Dade Camp
(D) Dental
(H) Health Center
(Fam. Plan., etc.)
WEST
18
20
Homestead
Air Force
Base
HOMESTEAD ( )
SW 312th Street
West (H) (D)
MOWRY STREET East
SD 21
10
Florida City ( )
Florida #27
Everglades
National Park
Rough Scale
½ in. to one
mile.
S.W. 137th Avenue
(Tallahassee Drive)
U.S. One
to Key West

1. Bailes Road Labor Camp
2. Borinquen Farm Labor Center
3. Brooks, J.R. Labor Camp
4. Bull, C.R. Labor Camp
5. Campbell Farms Lbr. Camp-East
6. Campbell Farms Lbr. Camp-West
7. Carpenters Lbr. Camp, Fla. City
8. Cox, H.L. Labor Camp
9. Cross, H.D. Labor Camp
10. Douberly, Everett Labor Camp
11. Douberly, Emmett Labor Camp
12. Far South Labor Camp
13. Krome Ave., Farm Housing Center
14. Kettles Labor Camp
15. Markhams Farm Labor Camp
16. Pearce Produce Labor Camp #1
17. Pearce Produce Labor Camp #2
18. Redlands Farm Labor Camp
19. Sanders Labor Camp - Eureka
20. Shaw, Marvin Labor Camp
21. South Dade Farm Labor Camp
22. Williams, Dan Labor Camp

LOCATION OF PERMITTED CAMPS AND CLINICS FOR THE 1967-1968 SEASON - TABLE B

(SCHEDULE FOR JANUARY, FEBRUARY, AND MARCH, 1968)

MEDICAL AND DENTAL CLINICS FOR MIGRANT FARM WORKERS AND THEIR FAMILIES
CLINICAS MEDICAS Y DENTALES PARA TRABAJADORES AGRICOLAS Y SUS FAMILA

PERRINE CENTER - 9879 East Fern St.
Across from the Fire Dept.

Wednesday (Mieroles)	6:00 p.m. to 8:00 p.m.

TALLAHASSEE CLINIC - Tallahassee & Bauer Dr.
26410 S. W. 137th Avenue, Naranja

Wednesday (Miercoles)	2:00 p.m. to 4:00 p.m.
Friday (Vierness)	6:00 p.m. to 8:00 p.m.

(Immunizations - 1st & 3rd Wednesday - 4:00 p.m.)

SOUTH DADE CLINIC - South Dade Labor Camp
S. W. 312th Street & 137th Ave., Homestead

Monday (Lunes)	2:00 p.m. to 4:00 p.m.
Tuesday (Martes)	6:00 p.m. to 8:00 p.m.
Thursday (Jueves)	6:00 p.m. to 8:00 p.m.

(Immunizations 1st & 3rd Monday - 4:00 p.m.)

KROME AVE. CLINIC - Krome Ave. Labor Camp
S. W. 162nd Ave. & 152nd Street

Monday (Lunes)	6:00 p.m. to 8:00 p.m.
Friday (Vierness)	2:00 p.m. to 4:00 p.m.

(Immunizations - 1st & 3rd Friday - 4:00 p.m.)

DENTAL CLINIC - Homestead
49 W. Mowry Street

Tuesday (Martes)	Appointments through
Thursday (Jueves)	medical clinics only

MATERNITY & CHILD HEALTH CLINICS
9879 East Fern St., Perrine
By Appointment Only - MO 6-2538

Monday (Lunes)	Child Health - Infants	1:00 p.m. to 3:00 p.m.
Thursday (Jueves)	Child Health - Preschool	1:00 p.m. to 3:00 p.m.
Wednesday (Miercoles)	Maty. & Family Planning	1:00 p.m. to 3:00 p.m.
Thursday (Jueves)	Family Planning	6:00 p.m. to 8:00 p.m.
Friday (Viernes)	Maty. & Family Planning	8:00 a.m. to 10:00 a.m.
Friday (Viernes)	Immunization	1:00 p.m. to 4:00 p.m.

(Schedule Continued)

MATERNITY & CHILD HEALTH CLINICS

177 West Mowry St., Homestead

Wednesday (Miercoles)----Child Health Care-----------------8:00 a.m. to 10:00 a.m.
Thursday (Jueves)--------Maty. & Family Planning-----------8:00 a.m. to 10:00 a.m.

Friday (Viernes)---------Immunizations---------------------1:00 p.m. to 4:00 p.m.

THERE WILL BE NO CHARGE FOR ANY SERVICE
(USTED NO TENTRA QUE PAGAR NADA PARA SERVICICIOS)

THESE HEALTH SERVICES ARE MADE POSSIBLE BY THE DADE COUNTY HEALTH DEPARTMENT, THE FLORIDA STATE BOARD OF HEALTH, AND THE UNITED STATES PUBLIC HEALTH SERVICE.

TABLE C

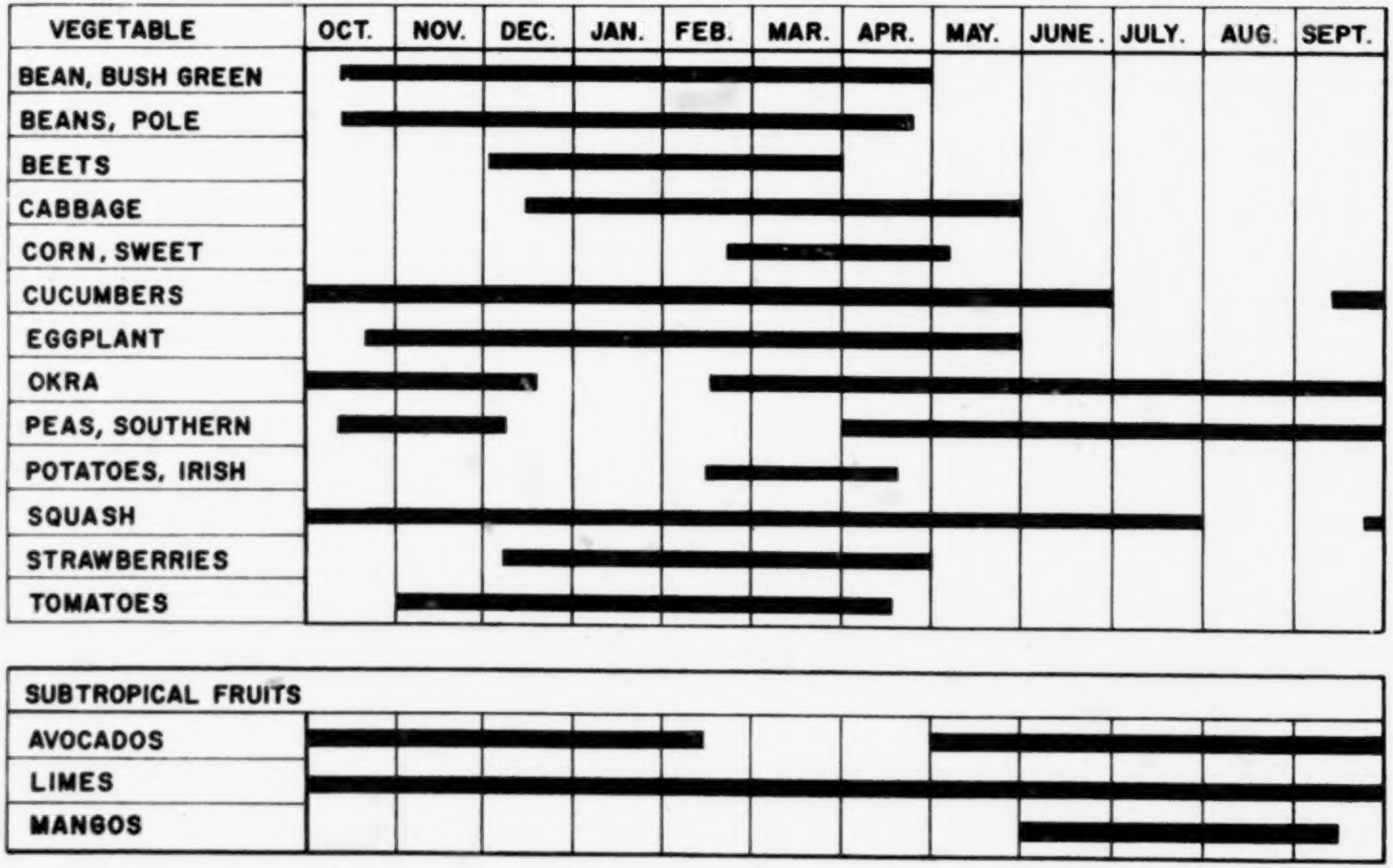
NUMBER OF PATIENT-VISITS AND NUMBER OF CLINIC SESSIONS CONDUCTED AT THE FOUR FAMILY HEALTH SERVICE FIELD CLINICS DURING 1967-1968 MIGRANT SEASON, BY MONTH, BY LOCATION, AND BY DAY OR NIGHT SESSIONS.

KROME	Oct.		Nov.		Dec.		Jan.		Feb.		Mar.		Apr.		May		Total Visits	Total Sessions
	(1)	(2)	(1)	(2)	(1)	(2)	(1)	(2)	(1)	(2)	(1)	(2)	(1)	(2)	(1)	(2)		
2-4 pm	N/C	0	N/C	0	56	3	117	5	137	4	99	4	119	5	28	3	556	24
6-8 pm	5	1	78	4	191	5	192	4	235	5	148	4	151	4	55	3	1055	30
TOTAL	5	1	78	4	247	8	309	9	372	9	247	8	270	9	83	9	1611	57
PERRINE																		
2-4 pm	N/C	0	N/C	0	N/C	0	N/C	0	N/C	0	N/C	0	N/C	0	N/C	0	N/C	N/C
6-8 pm	2	2	15	4	26	5	15	2	25	4	36	5	34	4	11	4	164	30
TOTAL	2	2	15	4	26	5	15	2	25	4	36	5	34	4	11	4	164	30
SOUTH DADE																		
2-4 pm	N/C	0	N/C	0	14	3	55	5	64	5	73	4	99	4	53	5	358	26
6-8 pm	40	3	121	4	273	5	276	6	383	9	208	7	354	9	99	8	1754	51
TOTAL	40	3	121	4	287	8	331	11	447	14	281	11	453	13	152	13	2112	77
TALLAHASSEE																		
2-4 pm	N/C	0	N/C	0	29	5	8	3	52	4	71	5	37	4	23	4	220	25
6-8 pm	30	2	123	5	90	3	177	5	164	4	128	4	94	5	34	4	840	32
TOTAL	30	2	123	5	119	8	185	8	216	8	199	9	131	9	57	8	1060	57
TOTAL 2-4 pm	N/C	0	N/C	0	99	11	180	13	253	13	243	13	255	13	104	12	1134	75
TOTAL 6-8 pm	77	8	337	17	580	18	660	17	807	22	520	20	633	22	199	19	3913	143
GRAND TOTAL	77	8	337	17	679	29	840	30	1060	35	763	33	888	35	303	34	4947	218

NOTE: (1)-Ref. to number of patient visits
(2)-Ref. to number of clinic sessions.
N/C-No Clinic

TABLE D

Table E



The year 'round harvest times for fruits and vegetables in Dade County is illustrated by the dark lines on the above chart.

SEASON ENDING	FRUITS		VEGETABLES	
	ACREAGE PLANTED	VALUE ($1000)	ACREAGE PLANTED	VALUE ($1000)
1959-60	16,600	1,952	40,565	22,921
1960-61	16,000	1,817	40,158	28,156
1961-62	13,595	2,955	37,540	30,643
1962-63	13,500	4,032	41,625	31,782
1963-64	13,020	5,196	49,170	37,354
1964-65	10,690	5,187	52,250	33,907
1965-66	10,750	4,059	44,680	33,723
1966-67	11,145	4,144	43,920	44,333

THE ACREAGE AND VALUE OF FRUITS AND VEGETABLES HARVESTED IN DADE COUNTY, FLORIDA FOR EIGHT SEASONS.

TABLE F

GLADES, HENDRY AND HIGHLANDS COUNTY HEALTH DEPARTMENTS

J. Dillard Workman, M. D., Director (Tri-County Unit)

GLADES AND HENDRY COUNTIES:

Area of GLADES County:	746 square miles
Resident Population:	3,200
Area of HENDRY County:	1,187 square miles
Resident Population:	10,600

HIGHLANDS COUNTY:

Area of County:	1,041 square miles
Resident Population:	22,000

MIGRANT HEALTH PROJECT STAFF:
(3 counties combined)

- 2 Public Health Nurses
- 1 Senior Sanitarian
- 1 Public Health Physician
- 1 Clerk-Typist

HEW-PHS
Wash., D.C.

PRETEST DRAFT
1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT

For May 1, 1967 through April 30, 1968
GLADES & HENDRY COUNTIES Date submitted May 23, 1968

PART I GENERAL PROJECT INFORMATION

1. Project Title
A project to develop a State-Wide Program of Health Services for Migrant farm workers and their dependents in Florida.

2. Grant Number (use number shown on approved application)
M.G. 18E (68)

3. Name and Address of Applicant Organization
Glades / Hendry Unit
Glades Co. HD, P.O. Box 274
Moore Haven, Florida 33471
Hendry Co. HD, P. O. Box 278
LaBelle, Florida 33935

4. Project Director
J. D. Workman, M.D., Director
Glades / Hendry CHD
P. O. Box 278
LaBelle, Florida 33935

5. Population Data - Number of Migrants (workers and dependents) for Glades/Hendry County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	1704	1102	602
Under 1 year	136	68	68
1 - 4 years	119	58	61
5 - 14 years	238	120	118
15 - 44 years	1191	843	348
45 - 64 years	17	12	5
65 and older	3	1	2
2. In-migrants			
Total	6828	4467	2411
Under 1 year	546	273	273
1 - 4 years	478	232	246
5 - 14 years	956	488	468
15 - 44 years	4768	3372	1396
45 - 64 years	68	97	21
65 and older	12	5	7

b. Number of migrants by month:

Month	Total	Month	Total
Jan	4872	Jul	2268
Feb	4910	Aug	2296
Mar	5320	Sep	3681
Apr	7865	Oct	6315
May	8106	Nov	6850
Jun	2376	Dec	7100

c. Average stay of migrants in county:
Out-migrants: 32 weeks
from Oct. (mo.) through May (mo.)
In-migrants: 16 weeks
from Oct. (mo.) through May (mo.)

d. Source of information and/or basis of estimates: Head count, etc - Employment service - Estimates (Nurses &Sanitarians Crew Chied & wife - Agricultural representative - clinic records

6. Housing accommodations for Glades / Hendry County:

a. Camps

Maximum Capacity	Number	Occupancy(peak)
Less than 10 persons	20	200
10 - 25 persons	2	40
26 - 50 persons	3	150
51 - 100 persons	3	225
More than 100 persons	6	1291

b. Other housing accommodations

Type	Number	Occupancy(peak)
Farms	201	2817
Other locations	549	3383

c. Append map showing location of camps, roads, clinics, and other places important to project.

PRETEST DRAFT
1967
Project No. M.G. 18E 68
Date submitted 5-23-68

GLADES AND HENDRY COUNTIES

PART II MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of visits
	Total	Male	Female	
Total	651	231	420	3578
Under 1 year	42	26	16	126
1 - 4 years	132	45	87	926
5 - 14 years	156	89	67	624
15 - 44 years	298	57	241	1824
45 - 64 years	19	11	8	57
65 and older	4	3	1	21

2. Patients hospitalized:

Age	Number of patients			Hospital Days
	Total	Male	Female	
Total	82	29	53	432
Under 1 year	34	17	17	131
1 - 4 years	2	2		13
5 - 14 years	4	3	1	21
15 - 44 years	37	4	33	177
45 - 64 years	5	3	2	90
65 and older				

3. Patients receiving dental service:

Item	Total	Under 15	15 and older
a. Number of migrants examined: total	45	12	33
Number of decayed, missing, filled teeth-	No Staff Dentist		
Average DMF per person	" "	"	
b. Individuals requiring services: total	27		27
Cases completed	15		15
Cases partially completed	7		7
Cases not started			
c. Services provided: total	318	59	259
Preventive	12	3	9
Corrective	153	7	146
Extraction	132	47	85
Other	21	2	19
d. Patient visits: total	45	12	33

4. Immunizations provided:

Type	Incomplete series	Completed immunizations, by age					Boosters, revaccinations
		Total	Under 1 year	1-4	5-14	15 and older	
All types	5	1036	105	311	235	20	360
Smallpox		44		25	11		8
Diphtheria	1	224	27	32	39	10	115
Pertussis	1	135	27	32	9		66
Tetanus	1	224	27	32	39	10	115
Polio	1	106	24	28	27		26
Typhoid		118		62	26		30
Measles	/	185		100	84		
Other (specify)							

Part II

Pretest Draft
1967
Project No. M.G. 18E 68
Date submitted 5-23-68

5. Medical conditions found by physicians among outpatients, by age of patient

GLADES AND HENDRY COUNTIES

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
I	Infective and parasitic dis.	334	21	59	20	215	19	
	Tuberculosis	9		2	1	2	4	
	Venereal disease	29				29		
	Measles	5		4	1			
	Infestation with worms	44	10	32	2			
	Dermatophytosis & other infections of skin	65	11	21	16	17		
	Other T.B. suspects & contacts	182				167	15	
II	Neoplasms	5				5		
	Malignant	2				2		
	Benign & unspecified	3				3		
III	Allergic, endocrine, metabolic, and nutritional dis.	104	40	27	11	25	1	
	Diabetes	8			2	5	1	
	Malnutrition	30	7	8	2	13		
	Other	66	33	19	7	7		
IV	Dis. of blood and blood-forming organs	10		3		7		
	Anemias	10		3		7		
	Other							
V	Mental, psychoneurotic and personality disorders	3				3		
VI	Dis. of nervous system and sense organs	112	18	55	19	14	6	
	Cerebro-vascular disease (stroke)	10				7	3	
	Eye diseases	35	5	26	3		1	
	Dis. ear and mastoid process	56	13	29	13	1		
	Other dis. of nervous system	11			3	6	2	
VII	Dis. of circulatory system	58			7	12	35	4
	Rheumatic fever	7			7			
	Diseases of the heart	2					1	1
	Hypertension & other dis. circulatory system	49				12	34	3
VIII	Dis. of respiratory system	286	22	104	100	57	3	
	Upper respiratory	260	17	89	97	54	3	
	Influenza and pneumonia	6	2	1	2	1		
	Bronchitis	20	3	14	1	2		
	Other							

Pretest Draft
1967

5. Medical conditions found by physicians among outpatients, by age of patient (Cont)

GLADES AND HENDRY COUNTIES

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
IX	Digestive system diseases	359	30	139	112	59	19	
	Teeth and supporting structures (gums)	5	3			2		
	Gastroenteritis, colitis	351	27	139	112	54	19	
	Other	3				3		
X	Dis. of genito-urinary system	41				18	23	
	Urinary system diseases	12				12		
	Genital system diseases	29				6	23	
XI	Deliveries and complications of pregnancy	25				25		
	Complications of pregnancy	2				2		
	Deliveries	20				20		
	Complications of puerperium	3				3		
XII	Skin diseases	57	19	8	23	7		
	Impetigo	25	3	4	18			
	Other	32	16	4	5	7		
XIII	Dis. of bones & organs of movement	36			5	15	16	
XIV	Congenital malformations	8		3	4	1		
XV	Dis. of early infancy	1		1				
XVI	Symptoms, ill-defined cond.	161			12	143	6	
XVII	Accidents, poisonings, violence	44	2	7	13	21	1	
	TOTAL OF CATEGORIES I-XVII	1644	152	406	326	627	129	4
SUPP	Special conditions, examinations, without sickness:Total	1934						
	Prenatal, postnatal care	399				399		
	Physical examination	301	11			277	13	
	Immunizations	917	65	341	421	90		
	Surgical or medical after-care, follow-up							
	Fitting prosthetic devices							
	Other family planning	317				317		

Pretest Draft
1967
Project No. M. G. 18E 68

Date Submitted 5-23-68

PART III NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number	Services provided:	Number
a. Visits to homes	528	f. Health supervision, counselling, teaching, demonstrating care ~~in~~ ~~homes~~ 353	528
b. Total households served	317	g. "Sick call" (nursing clinics) →	9 per wk
c. Visits to schools, day care centers: total	94	h. Referrals for medical or dental care: total	138
d. Migrants presenting health record on request (PHS 3652)	25	Within area: total	127
		Number completed	127
e. Migrants given health record	651	Out of area: total	11
		Number completed	11
		i. Other (specify)	
8. 1 No. of Individuals served.	951		

2. Sanitation services

Table A. Survey of housing accommodations of migrants

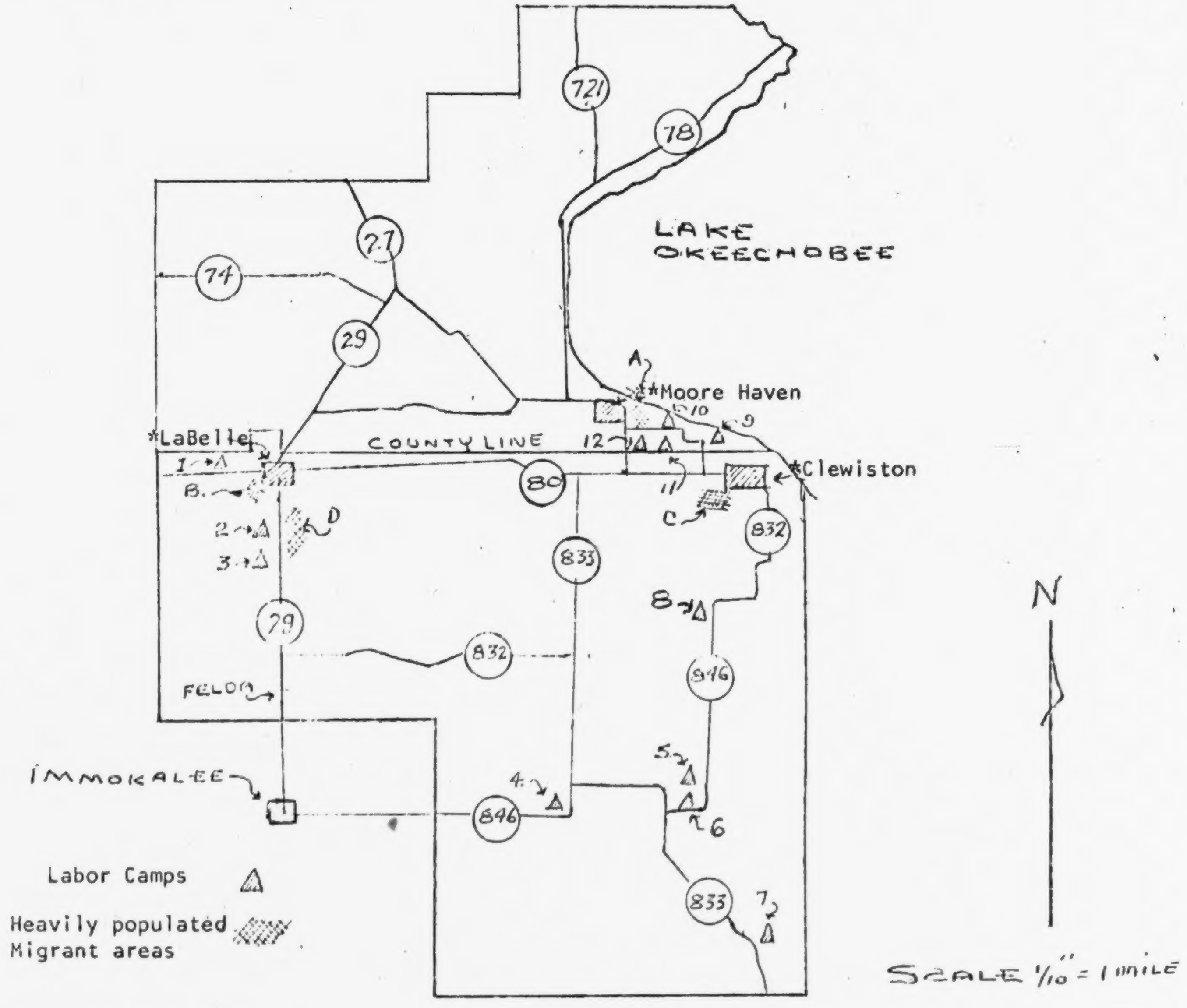
Housing accommodations	Total number	Number with Permits	Housing units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	34	8	28	2	90	6	6	1265
Urban or other locations	750	0						

Table B. Inspection of living and working environment of migrants

Item	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	78	90	8	6
b. Sewage	78	122	45	33
c. Garbage and refuse	78	87	19	5
d. Housing	78	178		
e. Safety	12	12		
f. Food handling	8	12		
g. Insects and rodents	12	12	1	1
h. Recreational facilities				
Working environment				
a. Water				
b. Toilet facilities				
c. Other				

* Locations - camps or other locations where migrants work or are housed

GLADES—HENDRY COUNTIES


721
78
LAKE OKEECHOBEE
27
74
29
A
*Moore Haven
10
9
*LaBelle
COUNTY LINE
12
1
80
*Clewiston
B.
11
D
2
3
C
832
833
8
29
832
846
FELDA
5
6
4
IMMOKALEE
846
833
7
N
SCALE 1/10" = 1 mile
Labor Camps △
Heavily populated Migrant areas ▨

1-Austin Labor Camp
2-Bob Paul Trailer Camp
3-Bob Paul Motel Camp
*4-6 L;s Labor Camp
*5-S & M #3 Labov Camp
6-S & M #2 Labor Camp
7-S & M #1 Labor Camp
8-Saunders Camp
*9-Shawnee Labor Camp

10- Benbow (U.S. Sugar Camp
11- Click Farms Camp
12- Glades Sugar Co-op
A- Moore Haven Migrant ARea
B- LaBelle Migrant ARea
C-Clewiston Migrant Area
D- Highway 29S LaBelle

* Indicates clinics

ANNUAL PROGRESS REPORT

GLADES & HENDRY COUNTIES

Period Covered: May 1, 1967 - April 30, 1968

Objectives:

1. To continue to improve the environmental health aspects of the migrants' existance.
2. To extend health education and general education to migrants.
3. To compile information on the migrant population through liaison workers.
4. To inform the general public and certain groups of the project's aims and migrant problems.
5. To extend the use of the referral system.
6. To offer more comprehensive medical and dental treatment to migrants. Many are in need of dental protheses. This is an especially serious problem with young women - not only because of nutritional but also because of cosmetic factors.
7. To extend family planning services to migrants.

There were no changes in objectives. No significant changes in the migrant situation occurred except that they are becoming more community oriented and many are purchasing homesites.

The seasons remain essentially the same. Farmers continue to plan for expansion. More emphasis is being placed on citrus as young groves mature to production age. Plans for construction of plants for packing fresh fruit, processing juices and by-products are being discussed.

Housing and health education are continuing needs.

Medical and Dental Services: Clinics

1. Clewiston Health Department, Clewiston, Monday morning, prenatal
   9:30 to 11:30 a.m.
   Monday afternoon, general - 1:00 to 3:00 p.m.
2. LaBelle Health Department, LaBelle, Thursday morning, prenatal
   9:30 to 11:30 a.m.
   Thursday afternoon, general - 1:00 to 4:00 p.m.
3. Glades County Health Department, Moore Haven, Wednesday afternoon, prenatal and general combined.

4. S & M Labor Camp, 35 miles south of Clewiston, Tuesday afternoon, prenatal and general combined - 9:30 a.m. to 12:30 p.m.

5. 6-L's Labor Camp, 6 miles west of S & M, Tuesday afternoon, prenatal and general - 1:00 to 3:00 p.m.

6. Shawnee Farms Labor Camp, 7 miles west of Clewiston, Wednesday morning, prenatal and general.

Conditions arising at times that cannot be served by clinics are referred to private physicians or dentists.

Health education is a part of most services rendered, and instructions must be repeated or reemphasized many times. Additional equipment and the services of a health educator would be beneficial.

Referrals to private physicians and specialists are completed without major problems. Funds for payment of physicians for inpatient care would be very beneficial and additional funds for patient transportation would allow for better use of referrals. Patients are willing to provide their own transportation as far as possible but many travel 200 miles round-trip for specialist care and cannot pay these expenses, especially during slow seasons.

The health department staff consists of two physicians, four nurses, five clerks, and three sanitarians. The addition of one clerk to take care of reporting and assist the nurse in referrals and follow-up would relieve the nurse for additional professional duties.

Hospital Care -

Patients are admitted on the recommendation of staff physicians. The personnel in charge of verification are contacted immediately and the patient is visited by a PHN as soon as possible. Verification is then made and the patient's condition is discussed with the hospital staff. Plans for discharge and follow-up are made as soon as feasible. The most needed addition, as mentioned earlier and which cannot be over-emphasized, is some reimbursement for the physicians.

Project/grower relationship is good. Some growers provide clinic sites, utilities, etc. One had crews transported some 20 miles to the clinic for PPD testing and x-rays after an active case of tuberculosis was discovered in a crew member.

Local churches have special projects for providing used clothing at little or no cost. Some outside consultation was provided by State Board of Health personnel as a part of their routine program.

Objective Achievements:

1. Environmental health aspects were improved to some degree. Lack of a project sanitarian for six months of the project period was a major problem. Much has been accomplished since one was employed in November, 1967.

2. Health education is important in each contact with the migrant, but its evaluation is difficult. The fact that the migrants continue to come to clinics for additional services and are willing to listen and consider

suggestions is some accomplishment.

3. Very little additional information on the migrant population is available, except that compiled by the staff. No voluntary agencies are active locally at present.

4. Problems of the migrant workers have been brought to the attention of local voluntary agencies and the general public.

5. The referral system was used satisfactorily.

6. A comprehensive medical/dental program is offered. Additional funds for dental protheses are still needed.

7. Family planning services were extended to include intrauterine devices.

Migrant workers and their families receive medical care at six clinic installations in Hendry and Glades Counties, and on occasion are referred for outpatient care at the Hendry General Hospital. The migrants living in or near urban areas attend the general weekly clinics in LaBelle, Clewiston, and Moore Haven health department offices. Special clinic facilities are provided for the migrant groups at three camps; Shawnee Farms in Glades County, S & M and 6-L's in Hendry County. The Shawnee camp in Glades County is made up of Negro families, lies between Moore Haven and Clewiston. The S & M and 6-L's Camps, with Spanish-speaking families of Texas-Mexican or Puerto Rican origin, are in the Devil's Garden area, about 35 miles southwest of Clewiston.

The staffs of the Glades and Hendry County Health Departments offer the migrant families all the services available to the general population, as well as some special facilities. Drugs are dispensed to the migrants from special supplies, and on occasion these patients are given prescriptions to be filled at project cost. All members of the health departments in Hendry and Glades counties come into direct contact with migrant families. These staffs include two physicians, four nurses, three sanitarians, and five persons on the clerical staffs. The Shawnee camp is visited for a morning clinic once a week by one doctor and one nurse. The S & M and 6-L's camps are visited by a physician, a nurse, and a clerk (one-half day per week), but on occasion other members of the staff are available. A second visit to S & M and 6-L's is made by the physician alone each week. Larger numbers of staff are involved at the urban centers, but the clinics there serve the general population as well as migrant families, and the attendance is much larger than in migrant clinics.

Regular services available to migrants in general programs of the counties include:

- Preschool examinations.
- Immunizations, including diphtheria, pertussis, tetanus, poliomyelitis (oral vaccine), typhoid, measles, smallpox.
- Chest x-rays at the annual visit of the mobile unit, with follow-up at diagnostic x-ray clinics, and prophylactic and therapeutic treatment, if indicated.
- V.D. control, including treatment of cases and prophylaxis for contacts.
- Prenatal and postnatal care, including urinalysis, blood testing for "serology," Rh factor, hemoglobin and glucose, weight control, and blood pressure.
- "Well-baby" examinations, and advice on care and feeding.

- Family planning advice, services, and supplies are available without charge at all clinics. In the past, intrauterine devices have been inserted by contract physicians only at the Clewiston clinic, but since early in 1968, the service and follow-up examinations have been offered at all clinics in the two counties. Other birth control methods available at no cost are "foam" and all the current hormone "pills."

Most migrant women have come to accept "birth control" with alacrity and enthusiasm, this probably being due in large part to their confidence in the nursing staff as a result of the personal interest our nurses show in the women and their families. Many of the younger women are serious about wanting to space their pregnancies and limit the size of their families. Pap smears are done on large numbers of patients in the two counties, and for this service the general public pays a small fee. The fee for this service to migrants is paid for by the Cancer Society. During the year malignancy is one migrant was detected, and this, early enough to permit a probable cure by a hysterectomy.

At all clinics considerable time and energy are devoted to instruction of mothers in general health as well as care and feeding of their families. Several pharmaceutical houses have made a generous response to our request for donations of vitamins and iron preparations for this special group of mothers and children. The mothers use these preparations as directed and are prompt in asking for "refills."

Health teaching is an integral part of all our activities and with the personal interest shown by the nurses in the migrant families, great strides have been made in the field of home sanitation and personal hygiene. With the purchase of supplies of small bars of soap for distribution to mothers, the cleanliness of children is much improved, and the incidence of filth diseases is much lower than usually found in groups of this economic level.

Home visits are not routine but many of these are made in the course of investigations (Tuberculosis, V.D., and the like) and the nurses have good knowledge of the general level of housekeeping and nutrition in these communities.

Special services provided for migrants:

Except for drugs used in special diseases; V.D., tuberculosis, rheumatic fever, only members of the migrant groups receive free medication from the health department, these supplies being purchased with project funds. On occasion migrants requiring treatment not available in our clinics are referred to contract physicians at the outpatient department of the Clewiston hospital. Patients requiring hospitalization have their hospital bills paid by migrant funds, but physicians' fees are not included in this aspect of the service. In special cases, a notable example being a laryngectomy performed because of malignancy, the Hendry County Commissioners have agreed to pay the physicians' fees.

Migrant patients are referred to Clewiston dentists for emergency dental care, this being limited to extractions and fillings. A goodly number take advantage of this service.

We have had excellent cooperation from all physicians and dentists in the two counties, and in some cases they have performed considerable services without charge. A retired surgeon in the area has also given us generous help without reimbursement. This cooperation of the medical and dental fraternities is very gratifying and would seem to indicate approval of our efforts and activities. The press in LaBelle

Clewiston, and Moore Haven has given us good cooperation and publicity. Lay persons have shown a gratifying enthusiasm in helping our "public" activities (mobile clinic chest x-rays, tuberculin testing in the schools, and in measles immunization campaigns).

As already mentioned, three of the camps, all at considerable distance from urban areas, have their own buildings for clinic purposes. While the facilities are not elaborate, they are adequate for our usual attendance. In one camp, the owner has shown special personal interest, making many improvements in the building we use, now providing us three rooms; one for the nurse, one for the doctor, and the other for office and waiting room. As an important sidelight, it is mentioned that at these three camps, all in isolated areas, the visits of the doctor, nurse, and clerk are something of a social occasion and mothers often bring their whole families, decked out in Sunday best, for very minor or even non-existent complaints. This might be considered a waste in an urban area, but the interest and friendship of the visiting medical group seems to mean a lot to these people, and probably contributes to a feeling of "belonging" and well-being. Most of the work, however, is of a serious nature and the staff has provided useful medical services for these deserving groups.

Future Hopes: Our health workers serving the migrant families are eager for an increase in our project funding, and entertain hopes for the provision of funds to pay contract physicians for hospital care of referred patients.

NURSING SERVICES

Nursing service for the migrant laborer and his family in Hendry and Glades Counties is provided by one full-time Project nurse. In addition, three non-project public health nurses employed by the Hendry/Glades County Unit contribute their services if migrants are located in their districts. This arrangement is not only administratively feasible, but also has merit in making each community and its service agencies aware of the migrant and his problems.

Objectives are to provide family counseling and health education to the migrant people. Duties are to provide comprehensive nursing service in all phases of a public health program.

Relationship with migrants and growers is good. Cooperation of the entire staff of the health department increases the effectiveness of the overall program.

Consultations from project nutritionists and health educators would be helpful. More health education materials in Spanish would also be helpful.

Regularly scheduled general and prenatal clinics are held at LaBelle, Clewiston, and Moore Haven. Migrant camp clinics are held weekly at three farms. Operators of these farms generously provide permanent buildings, water, lights, and at one camp, office and waiting room furniture. The migrant camp clinics are usually held from October until the middle of June when most workers and their families migrate in three general streams.

At the general and special clinics for the migrant, the Project nurse and health department nurses assist the physicians with examinations and medical care for the ill, make referrals to local physicians and specialists, give prenatal care and immunizations. Other services offered are tuberculosis and venereal disease detection and follow-up, school health physicals including vision and hearing tests, correction of defects, referral of children with crippling conditions, and cancer and diabetes casefinding. Family planning is emphasized and, in view of the number of individual requests for this type service, it is felt the idea has become more acceptable to all ethnic groups in this area. All approved methods of child-spacing are available and both visual aids and literature are used in group and individual instructions.

For several years these two counties have had far above the national tuberculosis rate per capita and much thought has been given to its source and spread, particularly among the migrant population. This year, casefinding efforts have been increased and have been productive. The mobile chest x-ray unit visited all migrant areas and the age limit was lowered to 12 years. The local Tuberculosis Association was active in this program and also arranged for tuberculin testing in the schools. Three first-grade migrant children who were positive reactors had chest x-rays and were placed on prophylactic drugs. Their families and close contacts were also tested. One adult, sleeping in a storage shed, was hospitalized for multiple severe rat bites. A routine chest x-ray revealed active tuberculosis and he was hospitalized immediately. His contacts were many as he had worked with several crews where a common drinking dipper was used. Special tuberculosis skin-testing clinics were held, positive reactors were x-rayed, one of whom had active tuberculosis and was hospitalized.

The LaBelle area has had an increase in the concentration of White, Mexican, and Negro migrants. Some rent whatever housing is available, others have purchased low-cost land and live in trailers while some have bought permanent homes. Six Negro families are building homes with Self-Help Housing. However, poor housing is still prevalent and it is obvious that the migrants' health status is directly related.

Inpatient Hospitalization became a reality in August, 1967, and has been a great asset to the program. The nurse who verifies migrant status has the opportunity to visit the hospitalized patient, make plans for future care, and advise him of all family services available in each area. This program has not been without problems, however. Several hospitals which provide specialized care have refused to contract for services to the migrant. One of these is the hospital which is used by the Tumor Clinic serving this area. This was definitely a hardship in two instances. One, a routine pap smear preceding insertion of an IUD, revealed conclusive cancer of the cervix. The patient was refused hospitalization at the Tumor Clinic Hospital and finally arrangements were made locally. Another patient, after being seen at a migrant camp clinic and referred to a private physician, was found to have cancer of the larynx. The same situation was encountered. After much time and effort, a private physician in an urban area nearby agreed to do the surgery, the county commissioners agreed to pay a partial fee, and the hospital in that area was partially paid by Project funds. This patient's problem merits special mention, since many agencies and individuals have been involved in his case. The local Cancer Society, has paid for all transportation, local and state welfare agencies, church groups, service clubs, and individuals have contributed food, clothing and housing for his family while he has been hospitalized. Plans are already underway for him to attend a sheltered workshop for rehabilitation.

In summary, it is felt that some progress has been made but many problems remain unsolved. Family planning has been made more acceptable and has increased in scope but many migrants have not yet been reached. Tuberculosis casefinding has increased and been productive, but efforts should be extended even more. Other agencies have made contributions to the migrant health program, and therefore, made many community groups and individuals aware of the migrant and his problems. Although many methods have been tried, the identification of the "free wheeling" migrant remains a problem.

It is felt that one full-time clerk is needed to relieve the project nurse and other personnel of non-professional duties. In this way more time would be available for family counseling and health education. The income of many migrants is adequate to provide decent housing and clothing, good nutrition, and recreation which is a necessity often neglected. However, some dynamic person should be available to motivate the migrant to spend his earnings wisely and profitably and achieve a greater degree of personal independence. It is hoped that in the next year, more time can be devoted to expansion of casefinding, home visiting, and individual and group counseling. Since the referral system seems to be a necessity for continuity of medical care, present methods should be closely examined and every effort made to improve and expand its usefulness.

SANITATION SECTION

The sanitation program for the migrant project in Glades and Hendry Counties was almost non-existent during the first six months of this report period. This was due to the fact that the bi-county unit was operating with only one non-project sanitarian. Because of his other duties and responsibilities he was able to give the project only minimum attention. In November, a full-time project sanitarian joined the staff. Since that time regular visits have been made to each camp and to the other migrant areas. The staff presently consists of one full-time project sanitarian assisted, as necessary, by two non-project sanitarians.

The sanitation program for the migrant project was a general environmental program. Almost equal time was spent on housing, sewage disposal and water supply. The six dormitory type camps also received routine food service inspection for each of their kitchens.

The accomplishments made in camps and migrant areas over this report period are detailed in later pages of this section.

In developing and carrying out this program, assistance was obtained from the sanitation division of the Florida State Board of Health. The migrant sanitarian was often in contact with the State Sanitation Consultant.

The housing accommodations vary greatly from new concrete block structures with modern and adequate plumbing facilities to small frame units served by sanitary privies. There were no tent camps used by any grower during the season.

A large number of migrants utilize existing vacant homes and other housing facilities which are available.

Each migrant camp is regulated and permits are issued in accordance with the Florida State Board of Health Rules and Regulations, Section 170C-32. A definition of a camp is cited in Section 170C-32.02.

New county zoning regulations which have been adopted in Hendry County will prevent the development of any additional substandard camps and will aid in the repair and improvement of the existing facilities. Obtaining corrections of structural violations is most difficult. Failure to comply initially is seldom intentional. In some cases it results from misunderstanding on the part of the grower. In some cases the grower is operating on leased land and hesitates to spend large sums of money to improve the property over which he may soon lose control.

In camps with central kitchens, food service facilities and food handling practices vary from meeting the minimum sanitary requirements to very satisfactory.

As would be expected, in many camps with a large number of people who practice poor housekeeping, insect and ordent control is a problem. Recreation facilities in most camps are non-existent except for those provided by the migrants. General cleanliness varies much from camp to camp and depends greatly upon the interest and participation of the grower.

The migrants are generally employed as field laborers and thus receive the advantage of fresh air, but little more. Water is usually supplied by a large keg-type container and is usually drunk from a common drinking cup. Sanitary facilities such as handwashing and toilets are non-existent.

Due to limited personnel, little effort was made toward health education. Many of our specific objectives were met and can be found in the narrative breakdown on camps.

Objectives for 1968-69:

1. To continue to improve general sanitation by regular camp area visits.
2. To establish better relations with the growers.
3. To assist operators and growers in formulating plans for new structures now under consideration.
4. To begin an extensive program of health education, where possible, using small group meetings at each camp and to utilize Spanish-speaking films and visual aids when appropriate for better communication.

Environmental Sanitation Report:

(1) W. F. AUSTIN LABOR CAMP
Highway 78, LaBelle, Florida

WATER: Artesian well, untreated, bacteriologically satisfactory

SEWAGE: Septic tank

HOUSING: Barracks with central kitchen

ACTIVITIES: Sanitarian made routine premise inspections; monthly water samples; had septic tank drainfield repaired and plumbing violations corrected. Sanitarian helped arrange schedule for migrants to attend tuberculosis slinics.

(2) BOB PAUL TRAILER CAMP
Highway 29 South, LaBelle, Florida

WATER: Well, untreated, bacteriologically satisfactory.

SEWAGE: Septic tanks for each trailer

HOUSING: Trailers - owned by migrants. Eight spaces for trailers.

ACTIVITIES: Sanitarian performed routine premise inspections, and monthly water samples. Slight contamination of water from vegetable sources was noted, and super-chlorination was recommended. This is an ideal type camp, in that the migrant has his own home, and the grower has to provide only the minimum of facilities.

(3) BOB PAUL MOTEL CAMP
Highway 29 South, LaBelle, Florida

WATER: Well, untreated, bacteriologically satisfactory.

SEWAGE: Septic tanks

HOUSING: New concrete block buildings divided into rooms for three families.

ACTIVITIES: Sanitarian performed routine premise inspections and monthly water samples. Septic tank drainfield was repaired and chickens and livestock removed as directed. Migrants instructed to have dogs inoculated for rabies control. This camp was observed by sanitarian and unofficially approved to see what care the migrants would give to the premises. The migrants upheld their promise to keep the camp clean and to limit the number of families to three so there would be no over-crowding. The migrants are very pleased with the accommodations.

(4) WILLIS LABOR CAMP
Highway 846 South, Hendry County

WATER: Well, untreated, bacteriologically satisfactory.

SEWAGE: Sanitary privies and septic tanks for showers.

HOUSING: Individual frame cabins, family units.

ACTIVITIES: Sanitarian performed routine premise inspections and took monthly water samples. It was reported to the owner that premises needed spraying for insects, and that two privies needed moving and covering, and others needed repairing and fly-proofing. Garbage was scattered all over the compound. Many dogs on premises without tages. The owner made a start at correcting these items but due to financial difficulties, decided to close camp and did so by January 8, 1968. February 2, 1968, camp deserted and partially moved.

(5) 6-L's CAMP
Highway 846, South Hendry County

WATER: Well, untreated, bacteriologically satisfactory

SEWAGE: Septic tank for central facilities

HOUSING: Frame, individual family units.

ACTIVITIES: Sanitarian performed routine premise inspections and took monthly water samples. Garbage control seemed to be the most pressing problem. The camp supervisor was requested to dig a large pit in which to bury garbage and this proved very satisfactory. The rest rooms became messy and it was necessary to install metal cans for holding waste paper.

(6) S & M CAMP #3
Highway 846 South, Hendry County

WATER: Well, untreated, bacteriologically satisfactory.

SEWAGE: Sanitary privies

ACTIVITIES: Routine inspections revealed scattered garbage, contaminated water, and untagged dogs with water supply being of first importance. The sanitarian advised the camp foreman to supply chlorine to treat the water supply. After several attempts at super-chlorination, samples of water were satisfactory. After this crisis, the foreman developed a better schedule of garbage collection and disposal. Sanitarian was disappointed that supervisor did not move and cover privies nor pump out elevated privies. Decision must be made as to future of camp.

(7) S & M CAMP #2
South Hendry County

WATER: Well, untreated.

SEWAGE: Septic tank for central facilities

HOUSING: Large concrete block building, divided into family cubicles.

ACTIVITIES: Routine inspections revealed slightly contaminated water and messy premises, including a hog pen. Sanitarian advised placing chlorinator in operation and clean-up of premises. A large abandoned septic tank was filled.

(8) SAUNDERS LABOR CAMP
*BWI Highway, 10 miles south of Clewiston, Florida

* British West Indies. Migrants are from Jamaica and Barbados. Sometimes referred to as off-shore labor.

WATER: Well, treated.

SEWAGE: Gang-type sanitary privies

HOUSING: Frame, barracks-type buildings for single men.

ACTIVITIES: Routine inspections revealed well run camp with excellent central kitchen. Some repair work was needed on chlorinator, but eventually a chlorine residual was noted. Drainfield area for kitchen waste water was filled and elevated. The camp manager announced tentative plans for new camp facilities within two years.

(9) SHAWNEE FARMS
Highway 720 North of Clewiston, Florida

WATER: Well, treated.

SEWAGE: Privies and septic tanks

HOUSING: Frame, single family units, and frame cottages for single men. Commissary on premises.

ACTIVITIES: Routine inspections revealed chlorinator not operating. Contaminated water; new well being drilled without permit; also laundry waste water on surface of ground and mess hall grease traps overflowing. These violations were corrected and a new toilet and shower room is under construction.

(10) BENBOW CAMP, United States Sugar Corporation
Highway 720, Moore Haven, Florida

WATER: Treatment plant on premises; water processed from Lake Okeechobee.

SEWAGE: Sanitary privies and central toilet and shower rooms served by septic tank.

ACTIVITIES: Benbow is an old, wooden village of frame buildings, picturesque, but primitive. The U.S. Sugar Corporation plans an entire new camp with masonry duplexes for families and later, new barracks for single men. Also included in their plans are new water treatment and sewage treatment plants. Routine inspections of this camp revealed a well-run, independent village with its own commissary. Sanitarian worked with water plant operator to make sure a chlorine residual was maintained in water system. Other than occasional repairs to plumbing, improvements were deferred because of the planned new buildings.

(11) CLICK LABOR CAMP
Highway 720, Moore Haven, Florida

WATER: Well, treated.

SEWAGE: Septic tank, central toilets and showers.

HOUSING: Barracks type, central mess hall.

ACTIVITIES: Small, well-run camp. Chlorinator installed as advised by sanitarian. Septic tank installed for kitchen waste disposal and for planned toilet room adjacent to mess hall. Clothes lockers planned for barracks.

(12) GLADES COUNTY SUGAR GROWERS, ASSOCIATION LABOR CAMP
Highway 27, Moore Haven, Florida

WATER: Well, treated.

SEWAGE: Package treatment plant.

HOUSING: Modern, metal barracks, central mess hall and recreational building.

ACTIVITIES: Routine inspections revealed no complaints from laborers. Water plant well run, (same water as for sugar refinery). Sanitarian made note that effluent from sewage plant was not chlorinated and final disposal into a pit, questionable. State engineer to be notified.

MIGRANT AREAS:

(1) Highway 29, South of LaBelle, Florida

WATER: Individual wells.

SEWAGE: Septic tanks and sanitary privies.

HOUSING: Individual houses and trailers on individually owned lots. Approximately 66 establishments, some with several trailers or small houses. There are 30 latin families and 36 caucasian families.

ACTIVITIES: Sanitarian made survey of this area and caused 30 sanitary privies and septic tanks to be installed. Water samples were taken upon request or complaint. Area subject to flooding, but the weather was dry this past year. New residents warned about possible flooding later. Area is now on the upgrade. The biggest problem is to keep the migrants from placing more than one trailer on each lot or homesite. They resent any county or state regulations.

(2) Colored Section, LaBelle, Florida (Ford Park)

WATER: City of LaBelle.

SEWAGE: Septic tanks.

HOUSING: Individual houses and several motel-type units. This is the old standard type colored section, housing mostly agricultural workers. Most of these consider LaBelle their home, but upon close questioning, reveal that they go out of the county at least once a year. The City of LaBelle has been most cooperative in getting shacks torn down and septic tanks installed where needed. City water and garbage collecting minimize public health problems. At certain times of the year there is over-crowding in some old shacks, but these are gradually being eliminated.

(3) Moore Haven Colored Section (just outside city limits, Glades County)

Old fashioned colored section, mostly permanent homes, but residents to leave county for work in summer. The fact that the section is outside the city limits makes improvements difficult. Open privies need to be eliminated. One entire block of substandard homes was condemned.

(4) Harlem, Colored Section, Clewiston, Florida

WATER: City of Clewiston.

SEWAGE: Septic tanks.

HOUSING: Approximately one-third new modern homes for colored, self-help housing project in planning stage. Approximately one-third old frame buildings being gradually modernized or eliminated. Large percentage of residents work for United States Sugar Corporation, but go north in summer to do agricultural work. Sanitarian had several rooming house violations corrected and has a program to improve garbage and septic tank conditions begun.

(5) City of LaBelle, Miscellaneous Migrants

WATER: City of LaBelle

SEWAGE: Septic tank or municipal system
City garbage collection

Many migrants rent houses on their own so they might be near schools and stores. The LaBelle Trailer Park accepts migrant families more that other trailer parks, even though they clutter the yards with trucks and old cars. Sanitarians inspect the premises for garbage, plumbing, and sewage violations. These migrants have all the advantages of a small incorporated community. A smaller number of individual families live just outside the city limits of LaBelle. Sanitarians have assisted in construction of sanitary privies, septic tanks, and plumbing repairs. Some of these people have access to city water. The City of LaBelle provides a free landfill for garbage disposal.

PRETEST DRAFT - 1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT
For May 1, 1967 through April 30, 1968
Date submitted May 15, 1968

HIGHLANDS COUNTY

PART I - GENERAL PROJECT INFORMATION

1. Project Title
A project to develop a statewide program of health services for migrant farm workers and their dependents in Florida

2. Grant Number (use number shown on approved application)
MG-18E-68

3. Name and Address of Applicant Organization

Highlands County Health Department
Courthouse Annex
Sebring, Florida 33870

4. Project Director
J. Dillard Workman, M.D.

5. Population Data - Number of Migrants (workers & dependents) for Highlands County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	2925	1706	1219
Under 1 year	214	110	104
1 - 4 years	388	200	188
5 - 14 years	648	330	318
15 - 44 years	1333	786	547
45 - 64 years	342	280	62
65 and older			
2. In-migrants			
Total	525	398	136
Under 1 year	12	7	5
1 - 4 years	52	27	25
5 - 14 years	110	57	58
15 - 44 years	250	200	50
45 - 64 years	101	98	3
65 and older	0	0	00

b. Number of migrants by month:

Month	Total	Month	Total
Jan.	2860	Jul.	1850
Feb.	2725	Aug.	1660
Mar.	2700	Sep.	1800
Apr.	2680	Oct.	2460
May	2410	Nov.	2790
June	2040	Dec.	2925

c. Average stay of migrants in county:
Out-migrants: 25 weeks
from Nov. (mo.) through April (mo.)
In-Migrants: 20 weeks
from JUNE (mo.) through Oct. (mo.)

d. Source of information and/or basis of estimates: Estimate based upon U.S. Dept. of Commerce, 1960: School Estimates, Crew leaders.

6. Housing accommodations for County: Highlands

a. Camps

Maximum Capacity	Number	Occupancy (peak)
Less than 10 persons	0	
10 - 25 persons	1	0
26 - 50 persons	3	39-35-0
51 - 100 persons	1	5
More than 100 persons		

b. Other housing accommodations

Type	Number	Occupancy (peak)
Farms		
Other locations		

c. Append map showing location of camps, roads, clinics, and other places important to project.

PRETEST DRAFT - 1967

HIGHLANDS COUNTY

Project No. MG-18E-68
Date submitted 5/15/68

PART II - MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of Visits
	Total	Male	Female	
Total	2145	801	1344	7094
Under 1 year	253	133	120	1003
1 - 4 years	837	398	439	3207
5 - 14 years	432	198	234	1296
15 - 44 years	223	33	190	449
45 - 64 years	327	22	305	664
65 and older	83	17	66	415

2. Patients hospitalized:

Age	Number of patients			Hosp. Days
	Total	Male	Female	
Total	70	35	35	305
Under 1 year	19	11	8	67
1 - 4 years	3	3	0	20
5 - 14 years	3	1	2	38
15 - 44 years	40	17	23	142
45 - 64 years	5	3	2	38
65 and older	0	0	0	0

3. Patients receiving dental services:

Item	Total	Under 15	15 and Older
a. Number of migrants examined: total	24	18	6
Number of decayed, missing, filled teeth	unavailable	--	--
Average DMF per person	unavailable	--	--
b. Individuals requiring services: total	24	18	6
Cases completed	0	0	0
Cases partially completed	19	13	6
Cases not started	5	5	0
c. Services provided: total	120	74	46
Preventive	6	4	2
Corrective	57	35	22
Extraction	29	21	8
Other	28	14	14
d. Patient visits: total	37	27	10

4. Immunizations provided:

Type	Incomplete series	Completed immunizations - by age					Boosters, revaccinations
		Total	Under 1 year	1 - 4	5 - 14	15 and older	
All types	1,095	235	26	124	25	2	60
Smallpox	--	25	0	21	5	0	0
Diptheria	277	55	8	20	3	2	24
Pertussis	242	42	8	20	4	0	12
Tetanus	277	55	8	20	3	2	24
Polio	202	22	2	14	3	0	0
Typhoid	97	8	0	7	1	0	0
Measles	0	28	0	22	6	0	0
Other (specify)	0						

HIGHLANDS COUNTY

5. Medical conditions found by physicians among outpatients, by age of patient:

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
I	Infective and parasitic dis.	1162	10	451	518	183		
	Tuberculosis	3				3		
	Venereal Disease	123				123		
	Measles	0						
	Infestation with worms	744		416	297	31		
	Dermatophytosis & other infections of skin	292	10	35	221	26		
	Other							
II	Neoplasms	9					9	
	Malignant	2					2	
	Benign & unspecified	7					7	
III	Allergic, endocrine, metabolic, and nutritional dis.	29	16	3		9	1	
	Diabetes	4				3	1	
	Malnutrition	19	16	3				
	Other Allergic	6				6		
IV	Dis. of blood and blood-forming organs	329			329			
	Anemias	327			327			
	Other Sickelcell	2			2			
V	Mental, psychoneurotic and personality disorders	15		6	4	5		
VI	Dis. of nervous system and sense organs	32		7	17	6	2	
	Cerebro-vascular disease (stroke)	5				3	2	
	Eye Diseases	0						
	Dis. ear and mastoid pro.	24		7	17			
	Other dis. of nervous system	3				3		
VII	Dis. of circulatory system	71			1	4	61	5
	Rheumatic fever	1			1			
	Diseases of the heart	2				2		
	Hypertension & other dis. circulatory system	68				2	61	5
VIII	Dis. of respiratory system	1272	81	306	379	193	235	78
	Upper respiratory	587	78	221	180	63	22	23
	Influenza and pneumonia	242	3	12	72	48	92	15
	Bronchitis	443	0	73	127	82	121	40
	Other							

HIGHLANDS COUNTY

5. Medical conditions found by physicians among outpatients, by age of patient (cont'd.):

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
IX	Digestive system diseases	469	12	81	88	87	173	28
	Teeth and supporting structures	132				17	92	23
	Gastroenteritis, colitis	334	12	81	88	68	80	5
	Other Diverticulitis	3				2	1	
X	Dis. of genito-urinary system	158	1	5	12	113	23	4
	Urinary system diseases	71	1	5	12	31	19	3
	Genital system diseases	87				82	4	1
XI	Deliveries and complications of pregnancy	95				95		
	Complications of pregnancy	8				8		
	Deliveries	86				86		
	Compli. of puerperium	1				1		
XII	Skin diseases	327		23	304			
	Impetigo	327		23	304			
	Other							
XIII	Dis. of bones and organs of movement	8		8				
XIV	Congenital malformations	12		2	10			
XV	Dis. of early infancy	0						
XVI	Symptoms, ill-defined cond.	1				1		
XVII	Accidents, poisonings, violence	1			1			
	TOTAL OF CATEGORIES I-XVII	3990	120	884	1671	696	504	115
SUPP	Special conditions, examinations, w/o sickness: total							
	Prenatal, postnatal care	186				186		
	Physical examinations	38		6	32			
	Immunizations	549	102	320	116	4	6	1
	Surgical or medical after-care, follow-up	122	15	13	32	42	15	5
	Fitting prosthetic devices	0						
	Other							
	Family Planning	117			6	111		

PRETEST DRAFT - 1967

Project No. MG-18E-68

Date submitted 5/15/68

HIGHLANDS COUNTY

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number	Services provided:	Number
a. Visits to homes (Total)	113	f. Health supervision, counselling, teaching, demonstrating care ~~in homes~~	296
b. Total households served 1)	65		
2)	60		
c. Visits to schools, day care centers: total	336	g. "Sick call" (nursing clinics)	
d. Migrants presenting health record on request (PHS 3652)	267	h. Referrals for medical or dental care: total	
		Within area: total	147
		Number completed	120
e. Migrants given health record	544	Out of area: total	21
		Number completed	20
1) In Clinic		i. Other (specify) Optometrist	5
2) In Field	0		

2. Sanitation services

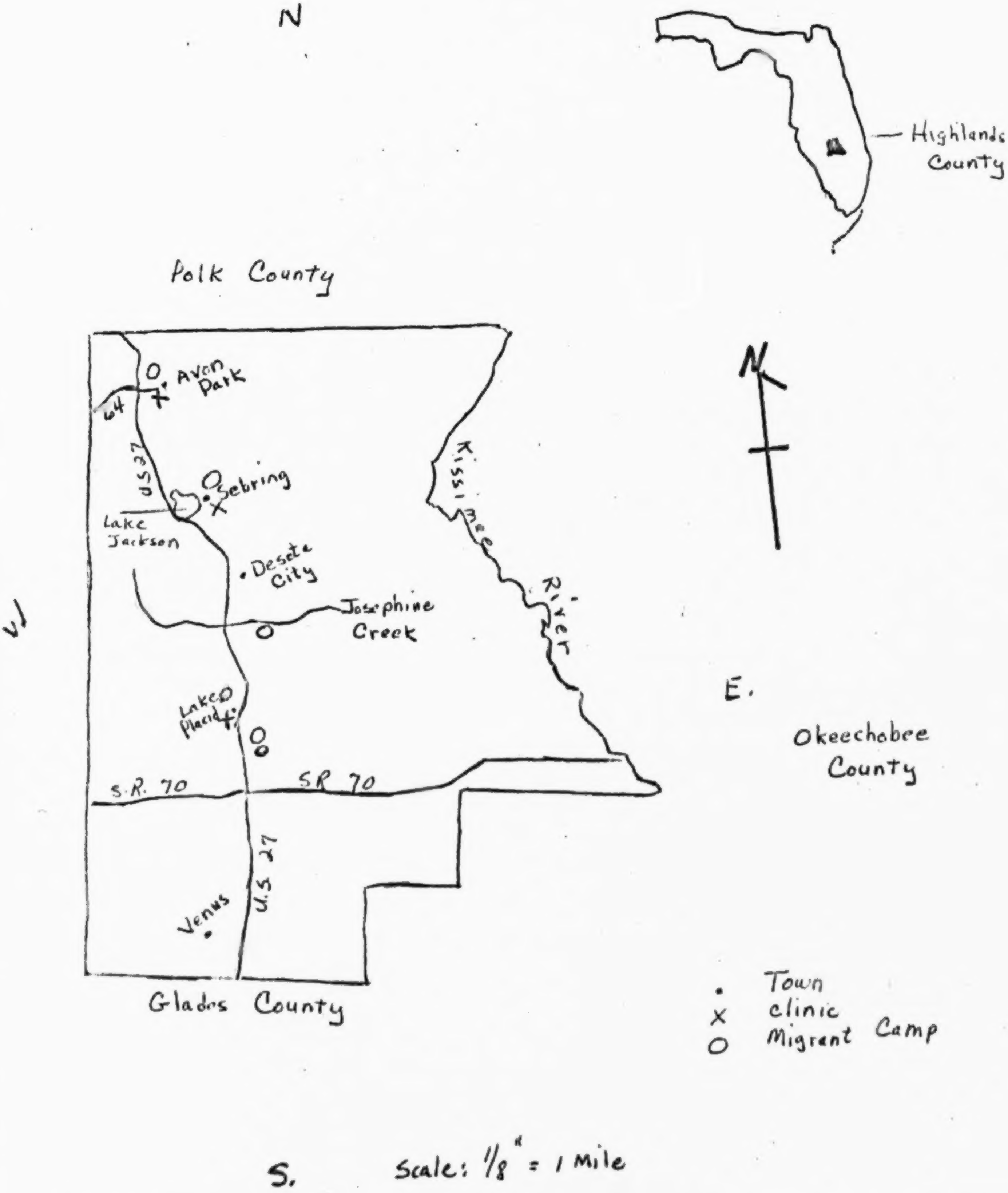
Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	5	0	1 - 8 Apts.	0	24	5	0	236
Urban or other locations	[illegible]		~~Other~~	~~Other~~	~~Other~~			

Table B. Inspection of living and working environment of migrants

	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	5	1	None	
b. Sewage	5	1	None	
c. Garbage and refuse	5	1	2	2
d. Housing	5	1	6	None Completed
e. Safety	5	1	3	None Completed
f. Food handling	5	1	2	None Completed
g. Insects and rodents	5	2	2	None Completed
h. Recreational facilities	0	0		
Working environment				
a. Water	None	Ice Cooler on Trucks		
b. Toilet facilities	None	None in Citrus Groves		
c. Other				

* Locations - camps or other locations where migrants work or are housed


N
Highlands County
Polk County
N
Avon Park
64
US 27
Sebring
Lake Jackson
Desoto City
Josephine Creek
Kissimee River
Lake Placid
S.R. 70
SR 70
U.S 27
Venus
W
E.
Okeechobee County
Glades County
• Town
x clinic
O Migrant Camp
S.
Scale: 1/8" = 1 Mile

EXPLANATION: Part III, #2, Sanitation Services

TABLE A: Survey of Housing Accommodations of Migrants

There are five camps in Highlands County. One is within the city limits of Sebring and the other four are located in the county. Two of these are about a mile below Lake Placid.

Another is half-way between Sebring and Lake Placid and the fourth one is on the outskirts of Avon Park (Lacy Hill Section).

None of these five camps were permitted last year because at the beginning of the season the owners did not intend to open the camps. Later in the year we discovered they were being used, but it was then too late to permit them.

Under Housing Units: The camps in the Avon Park area (Lacy Hill) consist of a barracks type building and another building consisting of eight apartments; of which four apartments were in use and contained a total of 24 persons.

All of the other camps in the county consist of single barrack-type buildings (dormitories) with a possible capacity of 236 persons.

TABLE B: Inspections

Inspections were made at all the camps and defects as indicated were found. These violations are being corrected but none are completely corrected at this time.

ANNUAL PROGRESS REPORT

HIGHLANDS COUNTY

Period Covered: May 1, 1967 - April 30, 1968

This report covers the period from May 1, 1967 through April 30, 1968, for Highlands County, Florida. The number of migrants in the county is approximately 3,000 with the majority being of the out-migrant group as this is considered by most as being their home base.

The main objective this year was to identify the migrant population as they are scattered among the general population. This has been most successful. It was carried on by the nurses, clerks, sanitarians, and the physician. Each individual was asked about his status and, in several instances, an almost house-to-house canvass was done by the nurses and sanitarians to see if the household contained migrants and if any one else they knew fitted the category.

We were thus able to extend our services considerably to this group. With a continuation of the project, plus the addition of increased Health Education on a personal day-to-day basis, it is felt that we can bring these people to a realization of a better environmental and personal health situation. We believe that increased utilization of personal health records is of great importance and this will be vigorously pushed in the ensuing years.

The migrants themselves are the same as in previous years. Their ages and sex composition does not vary. The ethnic background remains the same - Negro - with the cultural background being that of the southeastern United States with a few from Texas.

On leaving here they are planning to go to Georgia, South Carolina, North Carolina, Virginia, Pennsylvania, New York, Ohio, Indiana, and Michigan. A few plan on Tennessee and Illinois and some return to Texas for the summer months.

There was a great demand for the orange crop this season and it is continuing. The weather was excellent for harvesting, being quite dry and the price for picking per box was up thereby increasing the income considerably. Some of the better pickers have stated that they have been making $180. per week. The canneries have been operating at capacity and steadily increasing the earnings of workers and giving increased employment.

Highlands is citrus county and with an increase in planted acreage each year, and a larger production, the labor supply at times has been short. This has returned in longer hours and a consequent increase in pay. This should continue barring adverse weather conditions and market glut.

As yet there is not a successful mechanical picker for oranges. Several types have been tried without success. Grove maintenance on a mechanical basis is increasing, but the amount of acreage is keeping pace so that job opportunities are increasing slightly, even though mechanization is taking the place of some hand labor.

We feel that the movement of these folks into being out-migrants and the increase in year round maintenance employment will stabilize the population and enable us to increase our services and to give useful health education not only in the coming year, but for many years to come. By having the homemaker and children remain here on a year round basis, we can really give the services needed. The breadwinner who is the out-migrant receives services while here. Through the health education programs and referral program, he is aware of when and where to seek health services when away from here.

We hope that the increase in our service program will direct these people into a more healthful environmental and personal situation from year to year. We are desirous that this will continue to be our program this year and in the succeeding years.

General health clinics are held in Sebring on Tuesdays from 9:00 to 11:30 a.m. and 1:00 to 4:00 p.m. In Avon Park, on Wednesday, from 9:00 to 11:30 a.m. In Lake Placid, on Wednesday from 1:30 to 3:00 p.m. They are held weekly the year round in each location. An O.B. and family planning clinic is held in Sebring, the central location, on each Thursday from 9:00 to 11:00 a.m. This is staffed by two O.B.-GYN. physicians with delivery in the local hospitals in most instances. Transportation is furnished by the county from the outlying areas routinely.

A well-baby clinic is held once a month in Sebring on the second Monday from 9:00 to 11:00 a.m.; Avon Park on the second Tuesday from 9:00 to 11:00 a.m.; and in Lake Placid on the second Wednesday from 9:00 to 11:00 a.m. A retired pediatrician holds these clinics. Child development and health is stressed in these clinics and immunizations are started or continued, and feeding problems evaluated. These clinics see children from newborn to 12 years of age. Abnormal findings are referred to specialists for evaluation, care, and correction.

Arrangements have been made with the local physicians and dentists for care on a referral basis. This is partially paid for with migrant funds and in some instances by the migrant and Highlands County Welfare Department.

Health education is carried on by each staff member commensurate with their ability and knowledge as we do not have a staff educator. Pamphlets and direct conversation and instruction are the main avenues used for this purpose. Community areas are covered with various forms of education through leaders of the peers we are trying to reach. We find this quite successful in some programs and of little use in others. Ministers and "juke-joint" operators are one of the best sources for disseminating information and for voluntary action on clean-ups of the environment.

Referrals to the various state and voluntary agencies are made whenever the need arises and are followed through by making the appointment, arranging for transportation when needed, obtaining reports on cases, and aiding the recipient to follow-through with the treatment and after care.

The personnel of all the referral agencies are involved more or less with our cases. The County Welfare Department and Highlands County Chapter of the American Red Cross assist with transportation either by common carrier, personal car, or the Red Cross station wagon. Local physicians contribute their time to the clinics and also see migrants in their personal offices. Dental clients are referred directly to a private dentist either under project auspices or as a part of the obstetrical program. School children are taken care of by the health department dentist as well as preschoolers with simple needs.

Our nursing staff of one migrant project nurse and three health department nurses present the full program directly to the migrants. One health department nurse supervisor has full charge of the Migrant Hospital Program making personal visits to the hospitals and seeing that adequate post-hospital visits are made. Red Cross Volunteer Service Aides assist whenever possible in the school and hospital situations. They are particularly effective in the schools doing audiometric and vision testing. There are no other volunteers involved in the program.

The identifying of migrants, the obstetrical clinics, and the well-baby clinics plus hospitalization of the migrants have been the greatest and most needed changes and improvements in the past year.

We are hoping in the near future to add a local tumor clinic to our services and a local diagnostic mental and behavorial clinic service. These services are now available, but the distances involved and procedural workup necessitates delays and involvement of staff time that is limited to produce the desired program. To have these clinics locally situated and oriented will improve the quality and quantity of this service. We also feel that with the improved monetary position of the migrant we can deal more and more with health education on a productive and improved basis.

Both hospitals in the county take care of the migrants under contract arrangements. The health department is notified of the migrant's admittance to the hospital either by referral or by the hospital within 48 hours. The nurse in charge then makes a hospital and home visit for consultation with the patient and/or his family. Their status and needs are established and when necessary, the local county welfare department has assisted in paying the physician. This expense has become quite a burden on the county and we feel, as do the county officials, that some arrangements should be made to pay for physicians' fees for inservice care at the hospitals and post-hospital care in nursing homes.

In general, the experience has been good with the hospital program and the county welfare department has been able, so far, to pay for hospital care, when needed, beyond the 30 day period. We feel this is a good arrangement.

The migrants are eligible to receive all other services presented by the health department that county residents enjoy. Some of these include: Checking of food and water supplies; inspections of feed service and recreational facilities, inspection of and nursing visits to nurseries and day care facilities. The total services presented are too numerous and extensive to give in detail. All the personnel of the health department are involved in these from the janitor through the director.

The changes made from the previous year have been enumerated and a continuance and improvement in these programs is a necessity. As health education over the next few years improves, with a hoped-for improvement in the environment and general health, some specific direct programs aimed at the migrant can be decreased. This is the change we see for the future and we believe that improved environment and better health practices will bring about along with improved economic conditions as far as earnings are concerned.

Our relationship with the growers if of a minor nature because of the cessation of off-shore labor. Their camps are now closed and in most instances are devoted to other uses, or removed.

The Welfare Departments (both state and county) work with us and accept and send referrals whenever the need arises. As approximately 80 per cent of the migrants are Negroes, they are the chief recipients of this service in a much larger share than in proportion to their numbers. They are, in most cases, not economically sophisticated and consequently are in great need of economic consultation.

Referrals between local health departments is adequate and the material received very useful. The local medical society is very cooperative in all the programs and is very receptive to referrals and, in turn, makes referrals back to the health department.

The day care centers are doing a good job, but there is a need for more of them. They are restricted both by facilities and inadequate funds to increase their intake and to increase their services.

We have not been contacted by a farm labor representative on any matter. Sanitarians have conferences with the agricultural agent and the home economist provides programs from time to time. There has been no contact with Vista's since they left in the spring of 1967. We have found crew leaders very cooperative in seeing that their crew members get to the services that are required and they seem to take an interest in the health and welfare of their crews.

The Lion's Clubs in Avon Park, Sebring, and Lake Placid held glaucoma clinics that the migrants were urged to attend. We do not know how many, if any, did attend. They were notified of the clinics and their purpose.

We are aware of projects in other areas and make referrals back and forth. Also, we have had contact through meetings with their personnel. This has been very satisfactory.

We receive very little help from outside groups other than welfare, hospitals and the medical society in planning our project. The Highlands County Interagency Council is kept up to date on the project and the members collectively and as representatives of individual agencies are always ready with any assistance needed.

We see no changes needed, at present, in the future.

We are to receive from time to time consultation and assistance from the state level. This is in the form of directives and personal visits by state personnel.

Our personnel are stable and have been in the project directly or indirectly for many years. Conferences between personnel as a group are frequent and adequate. No changes are contemplated nor are new personnel to be added.

This past year has been quite successful in our migratory health program. We have been able to locate and offer services to our large group of out-migrants. These people are putting their roots down in this county and are becoming valuable adjuncts to the community.

In establishing their residence here they have expressed a desire to take part in the total community. In contacting them the nurses, sanitarians, and clerks have found that they are interested in becoming a part of the total community and in doing their part in building for the future. These folks, who were originally transient migrant workers, are now moving their families in and establishing residence. The heads of the family and the older members now go with the stream for the summer but the women and children remain with us.

We believe that this is a good thing. They have developed community spirit and pride. They are improving their surroundings and calling on the local health department for services and knowledge to improve their environment. The improvement in their personal health and environment induces others to follow their example. Many are accepting permanent year round employment. Many others are engaging in seasonal employment with the same growers and grove men each year. They have become dependable, ready, and willing seasonal workers. This extends to the summer migration patterns - returning to the same employer of the previous season.

We believe that this has come about by the acceptance and use by these people of the Migratory Health Program of this department. We feel, as time goes on, that these people will become more and more a part of the established community of this area and will become quite a vital force in the future development of the area.

Employment opportunities are increasing here with related industries coming in with the construction of manufacturing facilities for containers and the like for the bulb, citrus and cattlemen of the area. The ancillary features necessary for this increase are occurring with better housing, schools, and churches on the increase along with the personal services that are needed.

Our general health programs are increasing in scope and are being used more and more by the migrants. The immunization and family planning programs are being extensively used. We believe this to be an indication that the health education section of the health department program is successful.

In conclusion, the Migrant Health Program, we believe, is a stabilizing influence and an anchor for this work force. In addition, it is of great value, not only to the migrant worker, but to the community as a whole.

NURSING SERVICES

The nursing staff for the past year consisted of four registered nurses, including three staff nurses and a supervisor. Only one of the staff is salaried by the project, but all three staff nurses serve the migrants in their district. Since we are a home base for most of our migrants, they are intermingled with the general population and are best served by this type of staffing pattern. We have a fourth staff nurse position which we were unable to fill due to the limited budget.

We continue to find it difficult to identify our migrants because they are not located in any specific geographic area; and because more and more we see only the breadwinner moving on the season with the remainder of the family being year-round residents. By means of direct questioning by clerical and again by nursing personnel, we find we are identifying more each year. Other areas are assisting us in their identification, as we received more migrant referrals than ever before this year. The physicians and hospitals have been of assistance this year under the fee-for-service program and the Migrant Inpatient Hospitalization Program.

All consultation services used by Highlands County are non-project. In our county we have the services of a thoraic surgeon every two months for tuberculosis patients. At weekly intervals we hold a prenatal and birth control clinic staffed by one of two local OB-GYN physicians. As of May, 1968, we will have monthly well-baby clinics in all three municipal areas in the county staffed by a general practitioner.

Outside consultation is obtained in adjacent Polk County through the Florida Council for the Blind, Florida Crippled Children's Commission, Polk County Tumor Clinic, and the Mental Health Center of Polk County.

Transportation remains a problem but progress has been made in this area this past year. The local Red Cross Chapter has obtained a station wagon and assists us when possible. They are limited, however, by only having one vehicle and only a few volunteer drivers. The local County Welfare Department has provided a driver and vehicle to transport patients from the outlying areas to our weekly Prenatal and Birth Control Clinic.

The migrant health referrals forwarded to and from this area have met with a minimal amount of success. We will continue to improve the system by providing more identifying information, so that more patients may be located more easily. We would hope to improve and extend nursing services this next year by having sufficient funds to fill our vacant staff nurse position.

One of our Colored females, age 25, delivered a premature infant weighing two pounds. The infant was referred to J. Hillis Miller Hospital for pediatric evaluation and then returned to our local hospital until discharge, weighing five pounds, six ounces.

The mother, in turn, was referred to our weekly birth control clinic and an intrauterine device was inserted. A cytology, done at the time of insertion, was suggestive of malignancy and so a cone biopsy was done, followed by a total hysterectomy in a local hospital participating in the Migrant Hospitalization Program. Three local blood donors were procured, after much screening, for a rare type of blood.

SANITATION SECTION

Highlands County has five labor camps. One in Avon Park, consisting of two buildings, is owned by Manning Kirkland. One building has at present five men, the other building has apartments (eight), of which four are in use (17 persons) and are on city sewer and water.

Sebring has a new building, very modern, built in 1967, that will house 50 persons. As of February, 1968, 39 persons were in occupation of which nine persons remain. This building is owned by Sebring Packing Company and operated by them and is also on city sewer and water.

Lykes Brothers has a barracks-type building (old) in the Josephine Creek area East of U.S. 27, South of Sebring. This building will accommodate 24 persons (men) and is on septic tanks and has a well for water supply. It is vacant at this time.

There are two camps in the Highway Park Colored section of Lake Placid. One, owned by Consolidated Financial Corporation, is served by septic tanks and a water well and will house 40 men. This building is in very good condition. From October, 1967, to the present date there have been 35 persons there, of which 12 are now present. The other, owned by Nathaniel Hawthorne, was completed in the first of two stages this year and will house 40 persons in the first stage. No workers have been housed there up until now.

Not as much work was expended by the sanitation staff of this office this year as was done in previous years because fewer migrants applied for housing. Also, most of the persons who came to the county at the beginning of the season did not remain or found other places to live.

LEE COUNTY HEALTH DEPARTMENT

Joseph W. Lawrence, M. D., Director

Area of County:	786 square miles
Resident Population:	70,000
Migrant Health Project Staff:	2 Public Health Nurses 1 Sanitarian 1 Clerk-Typist

PRETEST DRAFT - 1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT
For May 1, 1967 through April 30, 1968
Date submitted May 13, 1968

LEE COUNTY

PART I - GENERAL PROJECT INFORMATION

1. Project Title
A program to develop a statewide program of health services for migrant farm workers and their dependents in Florida.

2. Grant Number (use number shown on approved application)
MG-18E (68)

3. Name and Address of Applicant Organization

Lee County Health Department
Post Office Box 1226
Fort Myers, Florida 33902

4. Project Director
Joseph W. Lawrence, M. D.

5. Population Data - Number of Migrants (workers & dependents) for Lee County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	3750	1875	1875
Under 1 year	100	30	30
1 - 4 years	750	400	350
5 - 14 years	1000	600	400
15 - 44 years	1500	1000	500
45 - 64 years	350	300	50
65 and older	50	40	10
2. In-migrants			
Total	7250	5000	2250
Under 1 year	150	80	70
1 - 4 years	500	300	200
5 - 14 years	550	400	150
15 - 44 years	5000	4000	1000
45 - 64 years	1000	750	250
65 and older	50	40	10

b. Number of migrants by month:

Month	Total	Month	Total
Jan.	9000	Jul.	250
Feb.	9650	Aug.	200
Mar.	11000	Sep.	2300
Apr.	6800	Oct.	3200
May	5850	Nov.	3400
June	1500	Dec.	4450

c. Average stay of migrants in county:
Out-migrants: 16 weeks
from June (mo.) through Sept (mo.)
In-Migrants: 36 weeks
from Oct (mo.) through June (mo.)

d. Source of information and/or basis of estimates: C.A.F., Farm Labor Bureau County Agricultural Agent & Staff

6. Housing accommodations for LEE County:

a. Camps Eleven (11)

Maximum Capacity	Number	Occupancy (peak)
Less than 10 persons	0	0
10 - 25 persons	1	50
26 - 50 persons	6	80
51 - 100 persons	3	100
More than 100 persons	1	500

b. Other housing accommodations

Type	Number	Occupancy (peak)
Farms Charleston Park*		*(Housing)
Other locations		150
Harlem Hgts	800	1500
Harlem Lake*	600	1000
Dunbar (County & City)	5800	9300

c. Append map showing location of camps, roads, clinics, and other places important to project.

PRETEST DRAFT - 1967

LEE COUNTY

Project No. MG 18 (E) 68
Date submitted May 13, 1968

PART II - MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of Visits
	Total	Male	Female	
Total	3012	907	2086	4655
Under 1 year	142	64	73	531
1 - 4 years	708	341	364	928
5 - 14 years	456	195	255	521
15 - 44 years	1452	209	1238	2406
45 - 64 years	244	95	149	254
65 and older	10	3	7	15

2. Patients hospitalized:

Age	Number of patients			Hosp. Days *
	Total	Male	Female	
Total	82	41	41	570
Under 1 year	23	11	12	145
1 - 4 years	6	5	1	36
5 - 14 years			NONE	
15 - 44 years	38	15	23	259
45 - 64 years	12	8	4	110
65 and older	3	2	1	20

*Hospitalized-26 yr old female
Mental Hospital

*Hospitalized
1 four yr old male to Tuberculosis Hospital
30 Yr old male to Tuberculosis Hospital
57 yr old male to Tuberculosis Hospital

3. Patients receiving dental services:

Item	Total	Under 15	15 and Older
a. Number of migrants examined: total	116	15	83
Number of decayed, missing, filled teeth			714
Average DMF per person	11	4	7
b. Individuals requiring services: total	98	15	83
Cases completed	39	7	32
Cases partially completed	62	8	54
Cases not started	6		6
c. Services provided: total	394	150	244
Preventive	38	30	8
Corrective	144	78	66
Extraction	182	42	140
Other	30		30
d. Patient visits: total	329	36	179

4. Immunizations provided:

Type	Incomplete series	Completed immunizations - by age					Boosters, revaccinations
		Total	Under 1 year	1 - 4	5 - 14	15 and older	
All types	162	1043	135	349		359	200
Smallpox	15	88	11	27		37	13
Diptheria	31	153	31	31		49	42
Pertussis	33	113	30	30		16	37
Tetanus	37	150	30	32		26	62
Polio	30	120	33	31		10	46
Typhoid							
Measles	16	66		51		15	
Other (specify)*							
*Mass Measles		353		147		206	

* Immunizations at Migrant Clinic Areas

LEE COUNTY

5. Medical conditions found by physicians among outpatients, by age of patient:

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
I	Infective and parasitic dis.	703	9	234	306	152	2	
	Tuberculosis	9		1		7	1	
	Venereal Disease	12				12		
	Measles	6		1	5			
	Infestation with worms	230	2	96	122	10		
	Dermatophytosis & other infections of skin		See Skin Diseases					
	Other	446	7	136	179	123	1	
II	Neoplasms	85				85		
	Malignant	2				2		
	Benign & unspecified	83				83		
III	Allergic, endocrine, metabolic, and nutritional dis.	22	1	6	3	10	2	
	Diabetes	9				7	2	
	Malnutrition	12	1	6	3	2		
	Other	1				1		
IV	Dis. of blood and blood-forming organs	71	1	38	13	11	8	
	Anemias	70	1	37	13	11	8	
	Other	1		1				
V	Mental, psychoneurotic and personality disorders	6				6		
VI	Dis. of nervous system and sense organs	66		36	15	11	4	
	Cerebro-vascular disease (stroke)	2				1	1	
	Eye Diseases	64		36	15	10	3	
	Dis. ear and mastoid pro.	NONE						
	Other dis. of nervous system							
VII	Dis. of circulatory system	48	1		1	13	33	
	Rheumatic fever	1			1			
	Diseases of the heart	2	1				1	
	Hypertension & other dis. circulatory system	45				13	32	
VIII	Dis. of respiratory system	690	117	132	143	184	87	27
	Upper respiratory	349	43	73	66	105	45	17
	Influenza and pneumonia	140	70	17	26	13	11	3
	Bronchitis	70	4	11	24	22	9	
	Other	131	0	31	27	44	22	7

5. Medical conditions found by physicians among outpatients, by age of patient (cont'd.):

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
IX	Digestive system diseases	88		41	11	30	6	
	Teeth and supporting structures							
	Gastroenteritis, colitis	88		41	11	30	6	
	Other							
X	Dis. of genito-urinary system	80			2	44	34	
	Urinary system diseases	56			2	20	34	
	Genital system diseases	24				24		
XI	Deliveries and complications of pregnancy	89				89		
	Complications of pregnancy	8				8		
	Deliveries	80				80		
	Compli. of puerperium	1				1		
XII	Skin diseases	268	67	67	58	64	12	
	Impetigo							
	Other							
XIII	Dis. of bones and organs of movement	59		2	15	23	19	
XIV	Congenital malformations	2	2					
XV	Dis. of early infancy	30	30				0	
XVI	Symptoms, ill-defined cond.							
XVII	Accidents, poisonings, violence	80		15	29	26	10	
	TOTAL OF CATEGORIES I-XVII	2387	228	571	596	748	217	27
SUPP	Special conditions, examinations, w/o sickness: total							
	Prenatal, postnatal care							
	Physical examinations							
	Immunizations	985	135	349	359	(Five and older)		
	Surgical or medical after-care, follow-up							
	Fitting prosthetic devices							
	Other * Planned Parenthood	116						

*IUD - 10
Pill - 96
Foam - 10

PRETEST DRAFT - 1967'

LEE COUNTY

Project No. MG-18E (68)
Date submitted May 13, 1968

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number	Services provided:	Number
a. Visits to homes	400	f. Health supervision, counselling, teaching, demonstrating care in homes	3
b. Total households served	1026	g. "Sick call" (nursing clinics)	276
c. Visits to schools, day care centers: total	1	h. Referrals for medical or dental care: total	151
d. Migrants presenting health record on request (PHS 3652)	6	Within area: total	116
		Number completed	28
e. Migrants given health record	51	Out of area: total	40
		Number completed	32
		i. Other (specify)	
Total # of Migrants served	3245	1. Hospital Verifications	1 83
		2. Number of patients not at home	2 100

2. Sanitation services

Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	11	3	8	0	695	3	3	160
Urban or other locations	5	0	5	0		0		17,350

Table B. Inspection of living and working environment of migrants

	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	12	24	0	-
b. Sewage	11	100	10	10
c. Garbage and refuse	17	242	51	51
d. Housing	17	942	40	40
e. Safety	17	229	40	40
f. Food handling	2	51	4	4
g. Insects and rodents	8	8	8	8
h. Recreational facilities	2	10	2	1
Working environment				
a. Water	4	4	0	-
b. Toilet facilities	4	4	4	0
c. Other	4	4	0	0

* Locations - camps or other locations where migrants work or are housed

NARRATIVE OF LEE COUNTY
ANNUAL PROGRESS REPORT

PART IV. General

This report covers 12 months, beginning May 1, 1967, and ending April 30, 1968. The objectives listed for the 1967-68 report year were as follows:

I. To continue to improve the health and living conditions of the migrants.

  A. By continuing to bring health services to the people, whether in camps or urban areas.

  B. By enlarging and improving the clinics already in operation.

II. To find a workable solution to the housing and boarding problem for the migrant discharged from the hospital, with no place to go and unable to return to work.

III. To increase services in the urban Negro area and seek out the migrant living in this community.

  A. By contacting the Farmers Market for their registry of crew leaders and contacting these crew chiefs to inform them of services available.

  B. By contacting the growers using these crews and making them aware of the services.

  C. By public health nursing home visits.

IV. Expand Family Planning Services

  A. The public health nurse in her home visits will help the patient to understand and accept "the pill."

  B. To urge those patients who cannot successfully take "the pill" to utilize an I.U.D.

V. To increase diabetic screening activities

  A. By doing diabetic screening in a booth at the State Fair in February.

  B. By increasing diabetic screening in clinics.

VI. To increase environmental sanitation services.

  A. Accident Prevention

    1. Home Visit: The public health nurse and sanitarian will increase the stress on accident hazards in all visits, as broken glass in the yard; insecticides in pop bottles; broken or weak steps; etc.

2. Utilize the State Board of Health Accident Prevention Consultant as to the most effective means of presenting educational materials on accident prevention.

B. Field Sanitation

1. To contact the growers and work out a solution for their particular problems.

2. To strive for some practical solution to the lack of toilet facilities for farm workers in the field.

Many of these objectives have been met. We have continued to improve the health and living conditions of the migrant by better sanitation, better heath education, and by the addition of a nutritionist who attends many of our clinics and is easily available for consultation.

We have moved the stationary trailer from Teter Road Camp to Charleston Park, thereby giving the nurse better working facilities. This clinic was formerly held in a camp owner's car port in Charleston Park with no sanitation facilities available and the nurse's work was greatly hampered. We still hope to persuade a doctor to conduct this clinic but as it is 20 miles from Fort Myers, and hospital facilities, this has not as yet been accomplished.

We rented a house at Teter Road Camp to replace the trailer moved to Charleston Park; repaired and renovated it, and then fully equipped it. At present this is our newest and largest clinic.

We have not been able to find a workable solution to the housing and boarding problem of the migrant discharged from the hospital with no place to go and who is unable to return to work. If he does not meet the one-year residency law, he can receive no help from welfare. Even if he could overcome this, our one small home for the aged and one nursing home have large waiting lists even for residents. This has been a very serious problem for the single migrant left behind when his co-workers leave. He has no money, is unable to work, and has not place to turn for help.

Services have been increased in the urban Negro area by establishing an IUD clinic held once a month in the evening hours and a family planning clinic from 4:00 to 6:00 p.m. weekly. These clinics are held at our Jones Walker Clinic where we hold an additional Thursday evening clinic. This clinic is in the center of the most densely populated Negro area.

We have a public health nurse of the same ethnic group who attends all of these evening clinics and makes home visits to seek out the Negro migrant who otherwise is so easily lost in the Negro community.

The crew chiefs and growers have been contacted about services available and better cooperation has resulted as we have become better acquainted with each other. It has been noted that the crew chief who imports families is more responsive on the whole than those who import all male crews.

The nurses have tried to stress all areas of public health in their home visits with special emphasis on family planning.

Services in this field have been expanded to include IUD's for patients who cannot successfully take the pill. There are presently 96 patients taking the pill, 10 using the foam, and 10 with the IUD's.

This clinic was just recently initiated so we hope to have an increase in the number of patients using this device next year.

The health department presented a diabetic screening program at the County Fair and many migrants were reached this way. Also, diabetic screening is done on all maternity patients and relatives of diabetics in the clinics.

The mobile x-ray unit was taken to the outlying clinics and camps this year during evening hours in order to reach the working migrant.

As yet, no practical solution to the lack of toilet facilities in the fields has been devised nor have the growers worked out a solution to this problem.

The public health nurses have been trying to help the migrant become aware of accident hazards. Accident Prevention is stressed during home visits with hazards being pointed out when noticed.

The migrant is encouraged to keep his home and yard clean, to keep garbage in a can with a tight fitting lid, and to keep his area free of pop bottles and broken glass. An item especially stressed is the safe use and storage of insecticides and the use of proper containers for inflamable materials.

The winter was quite mild this year and the migrants began arriving in early September. Their age, sex composition, place of origin and cultural background were approximately the same as the previous years; ie: 67% Negro; 7 6/10% Texas-Mexican; and 22 7/10% Puerto Rican. The only significant change was that a few more white migrants, mostly packing house workers, were found. We feel that they were always there, but with our expanded health services, they learned what we had to offer and availed themselves of these services.

The migrants in Lee County plan to follow the same stream pattern as in previous years, with a few more dropping out of the stream and becoming permanent residents. Self-Help Housing is encouraging this trend.

We are experiencing a longer season every year, especially in view of the severity of the winters up North and the mildness of our past one. Market conditions are staying good and only a few of the migrants have left to date. The big migration will start about the middle to the end of May.

The crops are essentially the same; tomatoes, squash, peppers, cucumbers, watermelons, and flowers.. Citrus industry is increasing each year.

There was little or no increase in mechanization in our type of crops and the labor needed is largely of the stoop variety.

As the migrant arrives in Lee County in increasing numbers, the need for health services rises. The wages are getting better, which in turn improves the economic situation of the migrants.

More money is desperately needed for hospitalization and some financial reimbursement for doctors serving inpatients.

The migrant clinics have continued to be heavily attended. We have added a weekly dental clinic, held every Monday evening from 7:00 to 9:00 p.m., which has been enthusiastically attended since the first session, this clinic has disclosed a great need for dental care in the migrant population.

Clinics
Locations and Hours

Monday	7:00 till 10:00 evenings Dental Clinic: Each Monday - 1st. and 2nd. Monday with Dr. Allen (Fort Myers); 34d. and 4th, Dr. Kagan (Fort Myers); with Dental Assistant and Lalai Perry, Clerk.
Monday	7:00 till 10:00 evenings I.U.D. Clinic: Jones Walker Hospital (Fort Myers), with Mrs. Ware and Mrs. Hennings (PHN's) and Dr. Hinkle.
Monday	9:00 till 12:00 noon Nurses Clinic: Mrs. Meston. Charleston Park (Alva - 22 miles from Fort Myers) 1st. and 3rd. Monday. Teeter Road Camp (7 miles south east of Fort Myers) 2nd. and 4th.
Tuesday	1:00 till 5:00 p.m. Nurses Clinic: Harlem Heights (6 miles south of Fort Myers) 7:00 till 10:00 p.m. Dr. Hagen and Dr. Boudreau, alternate with nurses Mrs. Meston and Mrs. Hudson.
Wednesday	7:00 till 10:00 evening Dr. Purvis and nurses, Meston and Ware - Teeter Road Camp.
	9:00 till 12:00 noon Maternity examinations, post-partum examinations Lee County Health Department (Fort Myers)
	1:00 till 5:00 Pap Smear Clinic - Lee County Health Department
Thursday	7:00 till 10:00 p.m. Jones Walker Clinic: Dr. Plummer and nurses Hudson and Ware.

Patients are still referred to specialists and for emergency care on a fee-for-service basis, but there is less demand for this since the expansion of our evening clinics.

We have started showing health movies at the Good Shepherd Mission at Harlem Heights in conjunction with our evening medical clinic in an endeavor to implement our teaching.

The minister's wife at the mission has given many hours of volunteer service acting as an interpreter. Also, the Catholic Nun has done the same at the Teeter Road clinic. We can always count on these people for help at any time. There is also a Gray Lady who volunteers her services one day a week at the mission and who has been of invaluable help.

This has been our first year of emergency outpatient care. An agreement was made with our local hospital for a flat fee for eligible persons. Again, there is no fee to pay the doctor and this has resulted in some strained relations.

Funds are needed for low-cost maternity care. At present, a delivery is by midwife for a fee of $75 for our clinic patients. Many of the migrants do not have the $75 and end up in the emergency.room. We can then help with their hospital bill, but this eats up a great deal of our woefully inadequate hospitalization allowance.

These hospitalization funds have helped the migrant greatly while they lasted, but our funds were exhausted in April and we still have May, October, November, and December which are heavy months for migration, with no funds for inpatient hospitalization.

Funds are needed for inpatient doctor's care. Our doctors have donated much time to these patients without pay and the doctors feel that if the hospital gets reimbursed, then they are entitled to it also.

We have had excellent cooperation with our local hospitals and medical society. Both our hospitals agreed to our format very readily, but Lee Memorial, being a much larger hospital, shoulders the major load. They have notified us very promptly of the patients in the hospital so that verification can be made immediately and predischarge planning started. We have been able to follow most of our patients until their complete recovery and return to work is achieved.

> Maria, a pregnant 19 year-old Puerto Rican, was the first migrant to utilize hospitalization in Lee County. Her baby girl was born with bilateral club feet. Cast were immediately put on each foot and changed every other day. At the end of ten days she was discharged. This child has been under orthopedic surgery care for the past ten months. The cast have been changed 16 times during this period. The mother has kept each appointment and has paid $4 per visit. The doctor has donated $6.00 (his usual fee for office calls being $10). A referral has been made as continuance of care is needed while this family follows the stream. The feet are improved and with care this child will soon have normal feet.
>
> Migrant hospitalization funds paid $270 of the mother and baby's bills. The patient paid $60. This leaves the unpaid balance $70. Without these funds this child would not have received prompt and proper care.
>
> "END MEASLES": March 17, 1968, was "End Measles Sunday" in Lee County. The total number receiving vaccinations was 4,946. A team was made up of one doctor, two public health nurses, migrant clerk, two Red Cross Aides, one Red Cross driver, and one Lee County Deputy Sheriff to serve the migrant area. Immunization centers were located in Charleston Park, Teeter Road and Harlem Heights. Three hundred, fifty-three migrant children were given the vaccine. One hundred, thirty-five children had been vaccinated at previous clinics.
>
> Two weeks after "Measles Sunday" five Mexican migrants were diagnosed as having measles by the doctor serving the Teeter Road clinic. A door-to-door survey was made and six more children were found who had not been vaccinated. They were on the "spot." One of the five children became ill and was sent to the hospital for five days with complications following measles.

There is a great need for an extended care facility for migrants without families but no solution to this is seen in the near future. This would provide continuity of care.

Our relationship with the Community Action Fund, Vistas, etc., has been excellent. The churches have contributed needed transportation, interpreters and financial help when needed.

No migrant day care centers are available at present. There are private nurseries with limited facilities. Charleston Park center is only open a few hours a day and serves mostly as a recreational type of facility. Day care centers are desperately needed, open at hours fitted to the migrants' needs. This would keep the older child in school and not at homecaring for the younger children, or worse yet, having too young a child left alone or locked in a house.

The community at Harlem Heights, spearheaded by the Vista workers, Migrant Mission Board, and several community leaders, is in the process of trying to establish a day care center. A room has been added to the mission building built with volunteer labor. They hope to have the center in operation by fall and its close promimity to our clinic will enable us to supervise the children's health needs and education.

Funds are needed for corrective and elective surgery for adults, both medical and dental.

We will also continue to try to solve our problems in transportation and comprehensive care for the migrant discharged from the hospital.

Our project staff has attended most of the meetings related to migrants held in Florida and the exchange of ideas has been very beneficial. It was interesting to learn at the Orlando Interstate Conference that our problems were not unique to Florida.

OBJECTIVES FOR THE COMING YEAR
1968 - 1969

I. To continue to bring health services to the migrant and his family and to expand these services.

    A. By seeking out the white migrant

        1. By contacting the Farmers Market for their registry of crew leaders and contacting these crew chiefs to inform them of services available.

        2. By contacting the growers using these crews and making them aware of the services.

        3. By public health nursing home visits.

II. To replace Jones Walker Clinic Building

III. To devise better methods of providing continuity of service.

    A. By the continued use of Migrant Health Referral System.

B. By the issuing of PHS Personal Health Records and stressing to the migrant the importance of these records.

IV. To put more emphasis on Family Planning

A. By having a public health nurse visit some of our local laundries and cleaners once a week, where many of the migrants dependents work, to hold family planning clinics during the break and lunch periods.

B. To offer Family Planning services in the low-income White areas at hours convenient to the farm worker.

V. To continue to seek a workable solution to the housing and boarding problem for the migrant discharged from the hospital, with no place to go and unable to return to work.

VI. To continue to increase environmental sanitation and safety

A. By continued efforts of the migrant staff in working with other agencies such as Vista, Self-Help Housing, and the Community Action Fund to educate the migrant to be alert to accident hazards in the home and field and the elimination of the causes.

B. To continue stressing the need for Child Day Care Centers.

C. By continued cooperation with those working to improve recreational facilities in Harlem Heights and Charleston Park areas, to insure protection and adequate sanitation facilities, and eliminate health and accident hazards.

NURSING

Staff - Project Personnel
2 PHN II
1 Clerk-Typist
1 Senior Sanitarian

Non-Project Personnel
1 PHN III - Paid by County
1 Gray Lady (Volunteer-Non Professional)
2 Interpreters (Volunteer-Non Professional)

Our project objectives this year are to try our best to help the migrant in every way possible to improve their lot in the fields of sanitation, nutrition, and economics by teaching them wiser spending habits and by trying to prevent unwanted pregnancies through emphasis on family planning. We also will strive to seek out the White migrant, previously lost to us, by visiting growers, packing hourses, and sections where we feel they might live and by any other means that prove feasible.

We will continue to strive for the cooperation of Vista, Community Action Fund, churches, and any other organization interested in the migrant's welfare.

We will try, by continued public health nurse visits, to bring up the level of immunizations to prevent any epidemic occuring. We can accomplish this easier by our numerous night clinics.

We still strive to detect TB in the early stages by the use of our mobile x-ray unit visiting the heavily populated migrant areas in the evening hours. The project nurses work with the unit to encourage more migrants to take advantage of this.

When we find cases we follow-up all contacts with PPD's and chest x-rays. Also, we try to find out the next address of the patients so that referrals may be made and continuity of service continued.

We try to seek out the pregnant migrant early enough to insure good ante partum and post partum care. The nurse visits the home both before and after delivery and supervises the care of the baby from birth as long as it is needed. She also evaluates the situation and advises as to nutrition and personal hygiene. In these early home visits, immunization is urged for the new baby. Special emphasis is given to the care of premature babies. We instruct the mother in the care of these small infants so as not to have undone all the work the hospital and doctor have accomplished in saving the child's life.

Cervical cytology is done on all post partum patients and patients on family planning. We urge all of our adult female migrants to have this examination.

We have all types of family planning available, having recently added the IUD. Literature both in Spanish and English is available and easily accessible in all of our clinics. We carry all literature on the care of the infant, feeding and family planning; plus vaginal foam on our first infant visits. We also do a PKU test on every new infant delivered by the midwives. This is a screening test for a metabolic disturbance which, if undetected in early infancy, can lead to mental retardation. This is the one form of correctible retardation.

We have many sources of outside consultation. These include referrals for visual and hearing defects through our local Lions and Civitan Clubs, Crippled Children's Commission, Vocational Rehabilitation, Florida Council for the Blind, and Operation Head Start.

Our County Dental Preceptor program serves many migrant children. We still need funds for elective and corrective surgery in adults. As the doctors get no fee for inpatient care, they will not accept this type of surgery except in rare instances.

We are partially solving the transportation problem by the payment of 10¢ a mile to interested carriers and by our strategically located night clinics. Sometimes it is hard to find even paid transportation; however, when everyone is working, so this remains a problem.

We still have the boarding and housing problem of the single migrant discharged from the hospital and unable to work. Even if he has a family and a home to go to, he has no funds to maintain it until he is back to work. As the migrant never can seem to save "for a rainy day" this is a serious threat to the wellbeing of the entire family.

The Community Action Fund has a school to educate the female migrant as a home aide attendant. This is a two-month course and a public health nurse gives a talk at the beginning of every class as to the services of the health department and the benefits offered by the Migrant Health Act. We also screen all the students for hearing, eye defects, dental defects, and serologies.

There is still a desperate need for child care centers. We have one for a few hours a day at Charleston Park and a few private ones, but hope to have a full-time one at Harlem Heights through community efforts and envolvement of the migrant himself.

Health films are being shown in conjunction with our night clinics. We have "flip" charts and literature on family planning - the public health nurse is constantly teaching health education on every contact with the migrant and his family.

Individual instruction and demonstration by the Health Department Nutritionist is received by each prenatal patient and all others having nutritional problems. Cases requiring special diets are referred to her by our clinic doctors.

The same form is used for all referrals, both local and out-of-state. We feel these work well when the migrants know where they are going and go there - they do not work out when the migrant leaves Florida with no idea as to his next stop or moves on up the stream due to crop failures or various other reasons before his referral reaches his intended destination.

Project objectives were substantially achieved with the exception of a few as yet unsolved.

Our night clinics have been well staffed by excellent doctors and dedicated nurses. They have been well accepted and attended. The clinics have been strategically placed in scattered locations far apart in the county so that evening clinics are easily accessible to migrants in all areas in the county at hours that they will not be working.

We have had excellent cooperation with church groups, crew chiefs, city and county officials, camp owners, and the migrant himself. We would like to give credit to all and to our clinic physicians and local physicians who work at a greatly reduced fee or no fee at all. The Lee County School Board has aided us immeasurably by donating clinic space and electricity. The community and many church groups have donated time, transportation, clothes, baby layettes, and even financial assistance when needed.

Our weaknesses are the lack of day care centers, need for more transportation than presently available, and the need for extended nursing care in nursing homes for single migrants.

Also, we still lack continuity of service up and down the stream, in spite of referral systems and the migrant's growing awareness of using the source. This is especially acute in the field of family planning with many migrants having successfully used a method in Florida, then returning pregnant from out-of-state.

We must further educate the migrant to carry his Personal Health Record, seek out the Health Department at his next stop, and present his record. This prevents so many un-needed immunizations and expensive repeat tests; such as G.B. series and G.I. series, etc.

So many of the migrants do not go to the place they were referred due to crop failures, etc., or if they do and find working conditions unsatisfactory, they will move on immediately. If we can educate the migrant to seek out the Health Department wherever he may be, this will prevent many "lost" migrant records.

Community participation is increasing every year as evidenced by the new planned day care center at Harlem Heights and the one at Charleston Park. The landlords are becoming more aware of the need for adequate housing and the stricter building codes are maintaining this. The grower is realizing he will get a more dependable worker if his physical comforts are more adequately met.

We have found a great need for dental care since our concentration on this field and the start of our weekly dental clinics. Of 83 patients receiving services, to date only three have completed work. There is a great need for replacement of teeth lost through extraction. At present, there is no money to replace teeth and the migrant hesitates to have all of his teeth pulled out when he has no money to buy plates. This is necessary in a great many cases due to the lack of proper dental care in the past; pyorrhea and gum problems, huge cavities too large to fill, etc. We try to stress proper dental hygiene at all clinics and are going to start to furnish tooth brushes with proper brushing instructions. Some migrants have never even owned a tooth brush and very few use them correctly. Their teeth have been neglected for years and some are too far gone to save.

We shall continue to do our best go give the best possible service to the greatest number possible through all means at our disposal, and through continuous health education.

We hope to find more unidentifiable migrants, both White and Colored, and acquaint them with our services.

We desperately need more money for hospitalization as ours was expended in the first four months. This shows a crying need for this type of service.

We shall continue to inform the general public and certain groups of the project aims and migrants needs, by participation in many organizations as Health and Welfare Council, Mission Board, church circles and civic clubs. The newspapers, radio, and T.V. have been most cooperative as evidenced by "End Measles Sunday." They published and broadcast both in English and Spanish.

We still need a doctor's clinic in the Bonita Springs area and Charleston Park area, but see no solution to this at present.

We hope to find a replacement area for the Jones Walker Clinic. This has been generously donated to us, but the local hospital needs our space there for storage due to the building of a new Lee Memorial Hospital and storing of used equipment. If no adequate facilities can be found at a reasonable rent, facilities could be utilized in the main health department.

CASE STUDIES

EVELYN: A three-year-old little Mexican girl pulled a pan of boiling water off the stove and scalded her upper torso and lower chin. She was admitted to the local hospital with third degree burns. The Shriners Club became interested in this child and flew her to their hospital in Texas where she received care and skin grafts. When she returned home, her grafts became infected and the child became very ill. Our local public health physicians have been treating the child and have cleared up all the infection. She returns to Texas in May for more grafting.

CARMELLO: An active far advanced T.B. case was found in one of our night clinics and was hospitalized. This man was married to the daughter of a very large Mexican family consisting in all of approximately 50 persons, counting all relatives concerned.

PPD testing was done on all the contacts, along with chest x-rays. Out of 50 people tested, 13 positive reactions were found. One 2-year-old son of the active case was also found to have T.B. and was hospitalized. The infant son has been in the hospital twice in the past two months and his diagnosis is doubtful as to T.B. He is being watched carefully. The wife was found to be mentally ill and admitted to Arcadia State Hospital. All the immediate family was placed on chemotherapy.

This family has been a problem every year that they return to Fort Myers. They live in crowded, insanitary conditions, in spite of all the health teaching and assistance given them. There is a high incidence of mental deficiency and illegitimate births in this family. The grandfather has been in prison for incest with a mentally retarded child. Six of the 11 children are mentally retarded and two of the grandchildren are mongoloids.

This family has availed themselves of every service we have to offer. We have implanted IUD's in the two oldest mentally retarded girls, and the rest of the adult girls are on birth control pills. We will continually strive to improve their standards of cleanliness and living conditions. They show a willingness to be cooperative by seeking us out and presenting us with all of their problems. All of the children have been immunized. This is one family that virtually could not exist without our services. We shall continue to try to get them to help themselves. We feel progress is being made through our teaching, but of course it is slow due to their low mental capacity.

SANITATION

The services of one full-time sanitarian, assisted when necessary by other sanitarians and the Director of Sanitation of the Lee County Health Department, are involved in the Migrant Health Project. This program is also greatly helped by staff and aides of S.W. Florida Self-Help Housing, Inc., and two Vista couples, one residing in the Charleston Park area and the other in the Harlem Heights area.

The environmental health conditions for the migrant are being gradually improved by a program of education of the landlords, camp owners, and migrants. The migrant project sanitarian is keeping a close check on the camps to see that they are being improved physically and to insure that they are kept up during occupancy. This necessitates a close and continuous contact with owners and migrants and is largely a matter of convincing both groups that better sanitation and housing is good for both. This is made possible by close cooperation with the project sanitarian, acting as counselor and inspector.

Our camps and other housing are continually improving and with continued effort by the sanitarian involving the people immediately concerned and the community and all existing agencies, including organizations favoring these improvements, this will be accomplished.

This sanitarian is working well with and having the full cooperation of the following groups: Harlem Heights Improvement Association; Harlem Heights Child Care Center Board; a Vista couple living in an area of Harlem who are particularly working for child care and recreation; A. & W. Farms; Thomas Farms and Bonita Farms (who are growers that are very cooperative); Farm Bureau representative; Home Economics Extension agent; S.W. Florida Self-Help Housing, Inc.; Lee County Clothing Center; Charleston Park Christian Council; Charleston Park Improvement Association; a Vista couple living in the Charleston Park area; Child Care Advisory Board of Lee County; City and County Building departments; the City Council of Fort Myers; and the Commissioners of Lee County; Lee County Health Department; Board of Education staff; and the Migrant Health Project nurses who work very closely with the sanitarian.

We have had excellent interchange of information and in-service training with counties having Migrant Health Projects with involved sanitarians visiting each other's counties. The problems are similar but each sanitarian has a somewhat different approach to them and the interchange of ideas is very helpful. Workshop meetings have been very helpful and necessary to understanding the total migrant picture. Meetings such as the Conference of Florida Migrant Health Project Personnel, the Eastern States Migrant Health Conference, and the Farm Labor Bureaus and Employers Conference.

The interchange between project counties and the attendance at Conferences should be continued as this keeps the problems in their proper perspective before the sanitarian and encourages a better local program.

Housing accommodations are usually of frame construction with a small amount of concrete block construction. One camp has concrete block construction, two camps use house trailers, and the others are of frame construction. The housing is generally poor to fair, but is becoming fair to good.

Camps are evaluated under the Sanitary Code of Florida, Chapter 170C-32. Housing in the City of Fort Myers is evaluated under a minimum requirement of the City Council passed in 1966 and in the County of Lee by a similar requirement passed as a resolution that same year by the County Commission.

A better climate locally is evident each year towards better housing. This has been brought about by the excellent cooperation and involvement of the above mentioned groups. The improvement is slow because landlords require time to make improvements as the housing generally is low rent.

Water and sewage is generally good, except in two county areas where sanitary privies are still used. Garbage and refuse is an ever-present problem, but by continuous check-up and education it is being greatly improved. The camps are being kept clean by having someone assigned to see that this cleanup is done.

The A & W Farms and Thomas Farms camps have satisfactory food handling, with good refrigeration; clean cooking areas; three compartment sinks. The other camps generally have family cooking, except Riviera Camp, where men eat elsewhere. Insect and rodent control is a part of the maintenance of the camp during season and off season. Camp owners usually provide a more complete insect and rat control program that ordinary landlords. Adequate areas for recreation are available in all camps, except the two at Charleston Park where a community program will be provided by the summer of 1968.

Water is furnished in the fields from portable water coolers and cold bottled drinks are available for handwashing in the field. Field toilet facilities consist of a few privies but due to the size of the fields, they serve little practical purpose.

Health education seems to cover more than educating the migrant to a better way of life with a desire for better housing and a knowledge of good sanitation. It seems to cover education of the landlord, grower, camp operator, and also the community in the desirability of attaining this goal. The sanitarian has worked with many groups and organizations, as well as individuals, to this end. This education is really being carried on by and with all the previously mentioned groups. Southwest Florida Self-Help Housing, Inc. is building homes in the areas of poor housing; Harlem Heights, Harlem Lakes, and Charleston Park. This building program provides a wonderful example to nearby residents and also to the total community. This is perhaps education at its best.

The sanitarian is really acting as a catylyst to others. By contact with these groups and individuals, a new concept of living is emerging for these people. It is becoming more and more evident that the migrant better understands that he has a responsibility toward maintaining his housing and keeping it in a more sanitary manner. The change in the migrant affects his relationship to the whole community. This relationship keeps changing for the better as both the migrant and the community get better acquainted with each other.

It is felt that continued effort on the sanitarian's part will move both groups closer together and benefits to both will become more and more apparent.

NUTRITION

Nutrition services were provided to migrants in Lee County from May 1, 1967, through April 31, 1968.

As a part of these services, diet counseling was provided to patients with nutritional problems, both in health department clinics and in home visits, when requested. The type of diet instruction and number of patients counseled were as follows:

Type of Diet Instruction	Number Counseled
Maternity	43
Weight Control	9
Diabetes	4
Child Health, etc	3

Health education films dealing with nutrition were shown by the nutritionist in the Harlem Heights evening clinic, utilizing the time while patients were waiting to be seen by the physician.

In Cape Coral there is a 12-week school providing training for migrant women desiring to learn maid work. The nutritionist spoke to this class of ten women on nutrition, attempting to show them the relationship of diet to various diseases and metabolic disorders.

Along with Mr. Terry Williams, Nutrition Coordinator for the Migrant Health Project, a series of in-service programs was started with the aides working with the Community Action Fund, Inc. It is hoped that these aides can be provided with a sound background in normal nutrition and food budgeting so that they can transfer this knowledge to the migrant families with whom they work. It is also hoped that these programs can perhaps serve as a pilot project for possible use with Community Action aides in other areas.

SUMMARY OF ANNUAL REPORT
of Project Grant #MG - 18
From May 1, 1967 to April 30, 1968

We have accomplished many of our objectives this year, but in order to give better service with more emphasis on family planning at suitable hours for the migrants, it is necessary that we continue with the present project staff with no reduction in our budget.

Additional funds are needed for hospitalization as our existing funds for 1968 were exhausted by April of this year.

One clinic at Teeter Road has been expanded and renovated. We will have to vacate our Jones Walker Clinic in June so we are trying to relocate in other quarters.

Our weekly dental clinic, which we added this year, is booked far in advance and has proved that there is a great need for dental care. Our Dental Preceptor is serving many of our migrant school children.

We plan to continue our night clinics (three medical and one dental) with the help of our local doctors and dentists. These clinics are strategically placed so that a clinic is easily accessible to most areas of our migrant population. They have all been heavily attended throughout the year.

We will continue to seek out the migrants so easily lost to us in the community with special emphasis on the white migrant.

The migrant discharged from the hospital with no home to go to still poses an unsurmountable problem at this time, but we will continue to work with community agencies to try to find a solution.

MANATEE COUNTY HEALTH DEPARTMENT

George M. Dame, M. D., Director

Area of County:	701 square miles
Resident Population:	81,000
Migrant Health Project Staff:	1 Public Health Nurse 1 Senior Sanitarian

[illegible]
Wash. ,D.C.

PRETEST DRAFT
1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT

For 1 May 1967 through 30 April 1968
Date submitted June 1, 1968

PART I GENERAL PROJECT INFORMATION

1. Project Title
A Program to Develop a Statewide Program of Health Services for Migrant Farm Workers and Their Dependents in Florida

2. Grant Number (use number shown on approved application)
MG-18E (68)

3. Name and Address of Applicant Organization

Manatee County Health Department
202 Sixth Avenue East
Bradenton, Florida 33505

4. Project Director

George M. Dame, M.D., Director
Manatee County Health Department
202 Sixth Avenue East
Bradenton, Florida 33505

5. Population Data - Number of Migrants (workers and dependents) for Manatee County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	900	488	412
Under 1 year	50	23	27
1 - 4 years	100	40	60
5 - 14 years	180	95	85
15 - 44 years	340	200	140
45 - 64 years	180	100	80
65 and older	50	30	20
2. In-migrants			
Total	5,000		
Under 1 year	250		
1 - 4 years	500		
5 - 14 years	1,000		
15 - 44 years	840		
45 - 64 years	260		
65 and older	250		
	10		

b. Number of migrants by month:

Month	Total	Month	Total
Jan 1968	2,625	Jul 1967	0
Feb 1968	2,025	Aug 1967	0
Mar 1968	2,490	Sep 1967	400
Apr 1968	2,350	Oct 1967	700
May 1967	2,495	Nov 1967	1,450
Jun 1967	375	Dec 1967	1,350

c. Average stay of migrants in county:
Out-migrants: 32 weeks
from Sept. (mo.) through June (mo.)
In-migrants: 12 weeks
from Mar. (mo.) through May (mo.)

d. Source of information and/or basis of estimates: Florida Employment Service County Agriculture Agent. Visits to camps homes and migrant school program

6. Housing accommodations for ______ County:

a. Camps

Maximum Capacity	Number	Occupancy (peak)
Less than 10 persons	0	
10 - 25 persons	1	20
26 - 50 persons	4	179
51 - 100 persons	3	203
More than 100 persons	1	138
	10	740

b. Other housing accommodations

Type	Number	Occupancy (peak)
Farms	5	20 (100)
Other locations	106	636 (2,554)

c. Append map showing location of camps, roads, clinics, and other places important to project.

PRETEST DRAFT
1967
Project No. MG-18 E
Date submitted June 1, 1968

MANATEE COUNTY

PART II MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of visits
	Total	Male	Female	
Total				
Under 1 year				
1 - 4 years				
5 - 14 years				
15 - 44 years				
45 - 64 years				
65 and older				

2. Patients hospitalized:

Age	Number of patients			Hospital Days
	Total	Male	Female	
Total				
Under 1 year				
1 - 4 years				
5 - 14 years				
15 - 44 years				
45 - 64 years				
65 and older				

3. Patients receiving dental service:

Item	Total	Under 15	15 and older
a. Number of migrants examined: total			
Number of decayed, missing, filled teeth-			
Average DMF per person			
b. Individuals requiring services: total			
Cases completed			
Cases partially completed			
Cases not started			
c. Services provided: total			
Preventive			
Corrective			
Extraction			
Other			
d. Patient visits: total			

4. Immunizations provided:

Type	Incomplete series	Completed immunizations, by age					Boosters, revaccinations
		Total	Under 1 year	1-4	5-14	15 and older	
All types							
Smallpox							
Diphtheria							
Pertussis							
Tetanus							
Polio							
Typhoid							
Measles							
Other (specify)							

Note: There was no dentist or hospital so outpatient services available.

#4. Patients were coded along with regular patients & there is no possible way to obtain these figures for the

Pretest Draft
1967

5. Medical conditions found by physicians among outpatients, by age of patient

Project No. MG-18E
Date submitted June 1, 1968

MANATEE COUNTY

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
I	Infective and parasitic dis.							
	Tuberculosis							
	Venereal disease							
	Measles							
	Infestation with worms							
	Dermatophytosis & other infections of skin							
	Other							
II	Neoplasms							
	Malignant							
	Benign & unspecified							
III	Allergic, endocrine, metabolic, and nutritional dis.							
	Diabetes							
	Malnutrition							
	Other							
IV	Dis. of blood and blood-forming organs							
	Anemias							
	Other							
V	Mental, psychoneurotic and personality disorders							
VI	Dis. of nervous system and sense organs							
	Cerebro-vascular disease (stroke)							
	Eye diseases							
	Dis. ear and mastoid process							
	Other dis. of nervous system							
VII	Dis. of circulatory system							
	Rheumatic fever							
	Diseases of the heart							
	Hypertension & other dis. circulatory system							
VIII	Dis. of respiratory system							
	Upper respiratory							
	Influenza and pneumonia							
	Bronchitis							
	Other							

No treatment on an outpatient basis was done by the Health Department.

Pretest Draft
1967

5. Medical conditions found by physicians among outpatients, by age of patient (Cont)

MANATEE COUNTY

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
IX	Digestive system diseases							
	Teeth and supporting structures							
	Gastroenteritis, colitis							
	Other							
X	Dis. of genito-urinary system							
	Urinary system diseases							
	Genital system diseases							
XI	Deliveries and complications of pregnancy							
	Complications of pregnancy							
	Deliveries							
	Complications of puerperium							
XII	Skin diseases							
	Impetigo							
	Other							
XIII	Dis. of bones & organs of movement							
XIV	Congenital malformations							
XV	Dis. of early infancy							
XVI	Symptoms, ill-defined cond.							
XVII	Accidents, poisonings, violence							
	TOTAL OF CATEGORIES I-XVII							
SUPP	Special conditions, examinations, without sickness:Total							
	Prenatal, postnatal care							
	Physical examination							
	Immunizations							
	Surgical or medical aftercare, follow-up							
	Fitting prosthetic devices							
	Other							

No treatment on an outpatient basis was done by the Health Department.

Pretest Draft
1967
Project No. MG-18E

Date Submitted June 1, 1968

MANATEE COUNTY

PART III NURSING AND SANITATION SERVICES

All figures are based on availab

	Number		Number
1. Nursing services (field nursing)		Services provided:	
a. Visits to homes	950	f. Health supervision, counselling, teaching, demonstrating care in homes	950
b. Total households served		g. "Sick call" (nursing clinics)	0
c. Visits to schools, day care centers: total	213	h. Referrals for medical or dental care: total	
d. Migrants presenting health record on request (PHS 3652)	0	Within area: total	75
		Number completed	
e. Migrants given health record	unknown	Out of area: total	4
		Number completed	
		i. Other (specify)	

2. Sanitation services

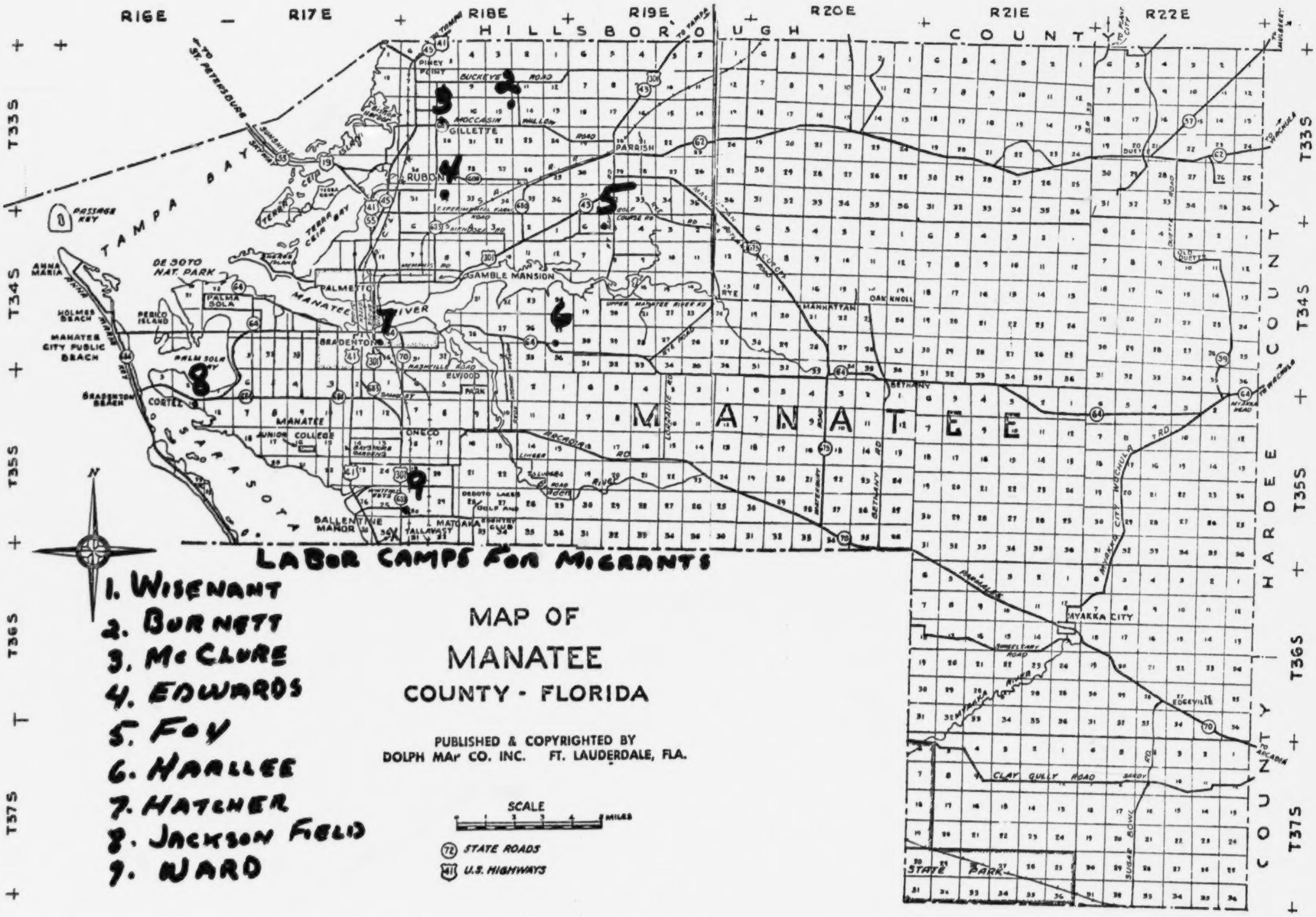
Table A. Survey of housing accommodations of migrants

Housing Recommodations	Total number	Number with Permits	Housing units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	10	7	17	0	0	2	2	136
Urban or other locations	0	0	111	0	0	0	0	

Table B. Inspection of living and working environment of migrants

Item	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	32	30	4	4
b. Sewage	20	20	3	1
c. Garbage and refuse	42	42	15	8
d. Housing	120	120	64	3
e. Safety	120	120	4	4
f. Food handling	25	25	8	6
g. Insects and rodents	10	10	6	6
h. Recreational facilities	2	1	9	0
Working environment				
a. Water	26	26	12	12
b. Toilet facilities	21	21	3	3
Other				

* Locations - camps or other locations where migrants work or are housed



R16E
R17E
R18E
R19E
R20E
R21E
R22E
T33S
T34S
T35S
T36S
T37S
HILLSBOROUGH COUNTY
HARDEE COUNTY
MANATEE
TAMPA BAY
SARASOTA BAY
TO ST. PETERSBURG
SUNSHINE SKYWAY
PASSAGE KEY
ANNA MARIA
HOLMES BEACH
MANATEE CITY PUBLIC BEACH
BRADENTON BEACH
CORTEZ
PERICO ISLAND
PALMA SOLA
DE SOTO NAT. PARK
TERRA CEIA
PINEY POINT
BUCKEYE ROAD
MOCCASIN WALLOW ROAD
GILLETTE
RUBONIA
PARRISH
GAMBLE MANSION
PALMETTO
MANATEE RIVER
BRADENTON
ELWOOD PARK
ONECO
MANATEE JUNIOR COLLEGE
BALLENTINE MANOR
TALLAVAST
MATOAKA
RYE
MANHATTAN
OAK KNOLL
BETHANY
DUETTE
OLD DUETTE
MYAKKA CITY
EDGEVILLE
MYAKKA RIVER
CLAY GULLY ROAD
SUGAR BOWL RD
STATE PARK
TO ARCADIA
TO WAUCHULA
TO MULBERRY
TO TAMPA
N

LABOR CAMPS FOR MIGRANTS

1. WISENANT
2. BURNETT
3. McCLURE
4. EDWARDS
5. FOY
6. HARLLEE
7. HATCHER
8. JACKSON FIELD
9. WARD

MAP OF
MANATEE
COUNTY - FLORIDA

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SCALE
MILES

72 STATE ROADS
41 U.S. HIGHWAYS

ANNUAL PROGRESS REPORT

MANATEE COUNTY

Period Covered: May 1, 1967 - April 30, 1968

I. General Information

A. Period covered by narrative report: May 1, 1967 through April 31, 1968

B. Objectives listed from last application. See reference letter attached.

C. Changes in objectives from preceeding project period.

D. Significant changes in migrant situation from last year. The most significant change or addition from last year is the well funded educational program for children of migrant agriculture workers. This program is designed to reach the migrant child from ages five through seventeen. These ungraded classes are located in all schools in Manatee County in the areas serving the migrant. This grouping has presented opportunities for reaching the migrant child for health education and medical care. Close liaison with the teachers and social workers of this program has been a source of more direct contact with the migrant child and the migrant parents.

1. The migrant themselves:

   a. The age and sex composition indicates some differences in the composition of migrants in that the Negro worker is somewhat older, 38 to 43 years, and there are more male "bachelor" workers of the Spanish-American groups. The Spanish-American is a family group averaging in age 35 years, with four children and in many cases a family member, a widowed relative or an older person.

   b. The southern Negro is closer to home and blends into the Negro community while the Spanish-American stands out as a migrant farm laborer. The Negro must be found since "day-haul labor" is nearly all Negro and these by-the-day laborers are residents of this county.

   c. The Texas-Mexican and the off-shore migrant stay as crews and usually serve under the same crew chief whereas the Negro is more loosely organized as crews.

   d. Generally the next move from this area takes place at the finish of the tomato crop in mid or late June. The majority of the migrants follow the east coast migrant stream and follow the crops through the southern states.

2. The economic situation

a. The windy cold winter advanced the vegetable crops three weeks this year. The resulting lack of work and the cold were additional hardships to migrant morale. These were indications of less money and jobs available and more moving of families, especially among the Spanish-American groups.

b. The early crop yield was below average due to the cold and dry winter; however, the spring crop, though late, promises to be a good one. The following are crops and acreage in which migrant labor is employed:

CROP	ACRES
Citrus	14,000
Strawberries	240
Cabbage	300
Watermelon	400
Tomato	3,400
Other	390

c. There were no significant additions in mechanization of labor but several large growers plan to change the type of labor they will hire next year. Two growers plan to go to permanent families and to build family housing and select their laborers from the "more stable" workers.

3. Comments on effect of the above elements

a. Education of the migrant child and adult is the best answer to their problem. The difficulty in accomplishing this objective is in selling this to the migrant himself. The most obvious need is family planning among these groups, both for the Negro and the Spanish-American. The migrant's life in general can be enjoyable, healthy, and useful, but his propensity for large families and the lack of sensible care for his children make him dependent on more outside help than is available.

b. The cultural background, the habits, and social mores of these people; Negro and Spanish, lead to grower hostility and distrust. The migrant must accept the growing indications that he must change his ways of living or continue to be scorned. Through educational persuasion and perhaps rejection, these changes may be imposed on the migrant.

II. General description of project operations during year

A. Medical and dental services

1. Clinics were held in almost every camp - see attached map. These clinics were held in the evenings on Monday and Tuesday in order that follow-up could be done during the latter part of the week. Some camps received more attention than others due to priorities established upon visitation.

2. The health department was without a dentist the greater part of the year. While one was available, he was able to screen all the migrant

school children and treat the most severe cases.

3. Health education is accomplished by the public health nurses and the migrant sanitarian.

4. Referrals were made to several local cooperating physicians, but the majority of care was handled in the emergency room.

5. During our migrant season, a great many personnel are involved as the period of time is comparatively short. These include the director of the health department, the director of nurses, four public health nurses, one clinic nurse, one clinic aide, one dentist, one dental assistant, one migrant sanitarian, one secretary, one clerk, and various volunteers such as husbands of personnel involved.

6. It will be easy to see that our migrant program has increased greatly in work volume and time spent on the program. A great amount of effort was allotted to screening the families and in particular the school-age children. Here was found a captive audience as the migrant school was quite active during this time. A great many additional personnel were employed in the activities of the program as the time period was so very short this year. It would have been feasibly impossible for project personnel to administer the program by themselves.

7. Much thought must be given to the project personnel. Although there is sometimes not enough work to keep them busy throughout the entire calendar year, justification of the use of funds is made by utilization of additional personnel during the busiest part of the year.

B. Hospital Care

At the present time, a migrant working in this particular county must make his own arrangements for hospitalization and physician's care. This is quite distressful to the migrant family as the cost of hospital care is far beyond their means.

C. Other Health Care Activities

All other health care activities with the migrants were centered in the county health department.

D. With the establishment of the migrant school, a large step forward in casefinding has been accomplished. There are also two full-time head start centers where children were screened and treated when necessary. A local church group has established a free day care center for infants and small children who, because of age, were ineligible for the other centers. Public relations with the growers have improved greatly. This is partly due to preventive medicine administered by the health department in the camps where meningitis was discovered.

E. Consultation received from outside project area.

Consultation was centered chiefly in the project area.

F. Other assistance needed

A part-time Spanish-speaking aide is needed to aid in doing a house-to-house survey and statistical recording. This part-time or full-time assistance would give direct contact with the migrant family and help in solving their problems.

G. Presentation of in-service training for new personnel consisted of:

Study of previous reports, attending the eastern states migrant health conference at Orlando, an orientation tour of Broward, Collier and Lee Counties.

The conference and the three county tour were excellent for in-service training of new personnel, as well as a fine refresher for anyone in the migrant program. I believe that a closer relationship between county migrant sanitarians in which problems are freely discussed would be of value. This could be by letter or by means of annual area meeting.

III. General appraisal of year's achievements

A. The migrant health program has been more successful this year than at any other time. A great many families were found and screened. Patients were most cooperative.

B. The biggest problem in achieving our goals is the short time period that the migrants are located in this particular county. Only immediate goals can be reached due to this situation.

C. Our personnel is our strongest point. They know the area, its problems, where the migrants would be located and how to work with them.

D. Utilizing as many personnel as possible during a concentrated period of time seems to be the only solution.

IV. Specific plans for the future to modify objectives, procedures, staff, relationships, etc. in the light of this year's experience.

More planning is necessary for this particular program. First of all, a work sheet must be devised in order that we can fill in the needed statistical data for this report. Better procedures for the clinics must be devised, along with referrals and treatment of those patients screened.

In essence, good planning holds the key to an effective program.

NURSING

I. General description of nursing service

A. Although there is only one staff member technically assigned to this program, basically, all including, administration and clerical help are included. This includes registered nurses, usually five or six at a time, along with aides and stenographers. All the staff is employed by this health department.

B. Basically, all nurses were concerned with casefinding, health education, physical evaluations, and referrals. School, home, and clinic visits were made.

C. The relationship developed by the nursing staff and other co-workers and various individuals is excellent. The nurses know the area and the project and are able to communicate rather well.

D. No outside consultation has been received except various visits from state officials. Administration did all the consultation.

E. Outside consultation is needed in planning. The particular problem is the most effective utilization of personnel.

II. Services provided to migrants

A. Camp visits and visits to the migrant school were initially made at the onset of the program. From these visits, goals were established and programs planned.

Clinics were held in the evenings. Patients were screened, referred or counseled depending upon the need. These patients are responsible for their own financial obligations for private doctors so many referrals were made to social agencies such as the welfare department, Crippled Children's Bureau, Salvation Army, etc.

Routine visits were made to all schools which have migrant children to see if there was any need for nursing service.

B. The only health education which was done was formally in the migrant classroom and informally in the home and clinic visits.

C. The referral system utilized is the one recommended by the State Board of Health. They are usually not very successful as most of these people do not know where they are going.

D. Same as above.

III. General appraisal of nursing program

The nursing program can be greatly improved by better planning. One nurse is not the answer to our situation. It would be so much better to submit time sheets and be reimbursed in that manner. For example, during the month of May, which this year was our busiest month, I could have used three or four nurses full time. During the month of September or January, perhaps one nurse one day a week would be sufficient.

Our biggest need in referral is funds for the private physicians and the hospital. These people simply cannot afford private medical care and this is our only recourse.

IV. Specific plans for future with reference to any modification of objectives, procedures, staffing, relationships, etc. in the light of this year's experience.

Specific plans are for adequate staffing. This is the primary need, followed very closely by the renovation of all procedures.

There is always a lack of staff and it is most imperative to utilize them correctly. Guidelines and procedures for the staff would be most helpful.

SANITATION

I. General description of sanitation service

   A. Staff involved

      1. Professional - one senior sanitarian, full-time and consultation and aid from six sanitarians as needed or directed.

      2. Other - at this date, there is no other volunteer aid used.

   B. Specific objectives and duties

      1. To keep camps and other migrant housing in a sanitary condition.

      2. To test drinking water frequently.

      3. To work with the grower and the crew chief for sanitary control.

      4. To look for and prevent the spread of disease through careless personal hygiene practices among the migrants.

      5. To help the mobile clinic in scheduling immunization and physical examination.

      6. To check the field sanitation conditions and practices.

      7. To inspect the sanitary facilities of camps and houses for compliance with the sanitary code.

   C. Work to be done and proportion of work accomplished

      1. To continue to improve the sanitary conditions in the field, as well as the living conditions of the migrant. Some improvement has been made here - more and better housing in one camp; the improvement of general conditions in all camps. Proportionally much is to be done yet, but measured against that already done, future improvements should be easier to accomplish.

   D. Relationships and involvement with migrants has been established by this office with growers, the local County Agriculture Agent, Head Start, the local church groups, the Florida State Employment office and the Migrant Education Project, the Florida State Welfare office and several private citizens who speak Spanish.

   E. Consultation outside the project consisted of attending the local council of churches, sponsoring the Rubonia Day Care Center. The new organization of 11 local churches organized to sponsor and finance several day care centers to be in operation this summer.

F. Consultation needed: More formal group meetings and discussions with growers, crew chiefs, and health department personnel (nurses, sanitarians, and director).

Closer relationship with the project director and other counties involved in migrant project: This may be accomplished by an informative circular or information sheet sent to each health department for the project sanitarians and nurses.

II. General description and conditions of migrant housing.

A. There are ten camps housing migrants. Two of these are within residential areas, though sub-standard, these have possibilities of being upgraded. Through the combined efforts of the Hotel and Restaurant Commission and the health department, these will be upgraded. Camp number three is metal and frame with central showers and laundry facilities with privy toilets. This camp is generally the "best" camp in sanitation and contentment of the migrant occupants. Camp number four is a combination of old motel units and a dormitory unit with privy toilets. Some vandalism from migrants and locals has been experienced here. Camp number five is planning some changes for next year. Camp number six is an obsolete school building that is gradually falling into disrepair. Camp number seven is an old motel units with central plumbing, started as a good camp, but migrant carelessness has degraded the general comfort and appearance. Camp number eight has improved but needs more supervision to keep general sanitation satisfactory. Camp number nine, the largest camp, is joint barracks and old-motel units, privies for the dormitories. Generally a good camp. Camp number ten, only used during tomato season, is old, small frame houses, generally a good camp for the short season it is used. One concrete block building in the Washington Park area is rented to migrants who consider this their own home base and has generally excellent facilities by comparison. Houses or shacks in the Rubonia area are generally substandard as are most private housing used by migrants. Those houses used in Bradenton have central water, sewage, and garbage collection but are generally substandard. The housing in east Palmetto is also generally substandard. Zoning and a local group are aware of these conditions, but improvement is complicated by many factors, one being that there is no other place in the county where the migrant can live.

B. Analysis of Table "A"

1. Permits are issued by the Florida State Board of Health, based on formal application by the owner and on the sanitary inspection rating and recommendations of the Manatee County Health Department.

2. Factors contributing to additions and improvements: (1) The increase in acreage used for vegetables; (2) Suggestions from the various governmental agencies (including standards set by the Florida State Sanitary Code). The individual houses are generally substandard and no appreciable progress toward improvement has been made due to social attitudes and apathy on the part of the migrant.

C. Factors of Table "B"

Water is available in camps and in housing meets health department quality standards, but quantity and convenience leaves much room for improvement. Sewage disposal in the camp areas is limited by the cost of installation compared with short time use and also by abuses of its use by migrants - rags in toilets, bottles and garbage in polishing ponds to mention some incidents that make the growers hesitate to install expensive equipment. Garbage and refuse disposal, though intelligently handled in two camps, is a problem in all the rest. This is an agreement that involves the owner-migrant relationship. Refrigeration in most camps is barely adequate and can be cured with a meeting of the minds. Cheap, used refrigerators are readily available.

(1) Food handling - formalized inspection of the three mess halls indicate fair sanitary practices and cleanliness on the part of the assigned cook. Most families cook on hot plates and get by with rudimentary sanitary practices. (2) Insect and rodent control is part of the sanitary inspection and is directly proportional to the care taken in food storage and garbage disposal. (3) Recreational facilities are generally lacking in the camp, though all have space for ball games. Two camps have playground swings. In the migrant school, the students were instructed by the migrant sanitarian in simple games that could be played anywhere with a minimum of equipment. These games consisted of relays, kick ball, etc.

General cleanliness in camps has improved over last year. Possibly this is due to emphasis on this in other areas as well as local efforts.

III. General work environment - The use of the community tin dipper still persists among some work groups. Toilets generally are sled mounted and barely adequate in most cases. The sanitary commercial privy is hard to sell here but this will be pursued more diligently. Hand washing is sketchy to non-existant in the field. Continuous effort is needed to persuade the migrant and the grower that this is a source of disease, lost work, time, and money.

IV. Efforts in health education

We plan to teach basic sanitation, personal hygiene, camp sanitation, causes of disease and mean of transmission, child care, and reasons for immunization against disease. Method of implementation - by means of frequent nurse-sanitarian lectures at camp sites and in schools. Demonstrations by nutritionists in food preparation and demonstrations using laboratory plates and educational films.

V. A. General appraisal of sanitation program: There is a pressing need for
& migrants to learn more about sanitation and diseases afflicting man.
B. More emphasis is to be put on direct contact with the migrant, including adult education. The important of the sanitary program generally does not reach the migrant in such a way as to impress him. A case of meningitis in one camp appeared to impress the migrants of that camp more than any series of lectures could.

VI. Plans for future health education based on this year's experience:

Objectives

1. To schedule class instruction for migrant children with the school authorities.

2. To see that each camp views films on camp sanitation.

3. Through night clinics, include personal hygiene instruction.

HEALTH EDUCATION

I. General description

A. Staff involved

1. Nurses and one sanitarian

B. Objectives

To teach personal hygiene to school children and adults. The migrant special school in Palmetto was used as an experiment in a series of illustrated lectures by the sanitarian, consisting of taking smears and water washes from the hands of the students, observation of the resulting laboratory plates was followed by instruction on the use of disinfectants and hand washing. Several films on food handling, diarrhea and personal cleanliness were shown in the Spanish language. Nurses instructed mothers on simple hygiene practices in the home and for the care of children.

It was found that during mobile clinic visits to camps and housing areas that it was the best time to give food demonstrations (Mr. Terry Williams and his assistant) and to show Spanish language films on sanitation.

MARTIN COUNTY HEALTH DEPARTMENT

Neill D. Miller, M. D., Director

Area of County:	568 square miles
Resident Population:	16,900
Migrant Health Project Staff: (*) Part-Time	1 Public Health Nurse (*) 1 Senior Sanitarian 1 Clerk-Typist II (*)

PRETEST DRAFT - 1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT
For May 1, 1967 through April 30, 1968
Date submitted May 9, 1968

PART I - GENERAL PROJECT INFORMATION

1. Project Title
A program to develop a statewide program of Health Services for Migrant Farm Workers and their dependents in Florida.

2. Grant Number (use number shown on approved application)
MG 18E (68)

3. Name and Address of Applicant Organization
Martin County Health Department
Post Office Box 1846
Stuart, Florida 33494

4. Project Director
Neill D. Miller, M. D.
Post Office Box 1846
Stuart, Florida 33494

5. Population Data - Number of Migrants (workers & dependents) for Martin County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	21	11	10
Under 1 year	4	4	0
1 - 4 years	3	1	2
5 - 14 years	6	2	4
15 - 44 years	6	3	3
45 - 64 years	2	1	1
65 and older			
2. In-migrants			
Total	1115	520	595
Under 1 year	40	25	15
1 - 4 years	190	85	105
5 - 14 years	185	95	90
15 - 44 years	600	275	325
45 - 64 years	75	30	45
65 and older	25	10	15

b. Number of migrants by month:

Month	Total	Month	Total
Jan.	1,000	Jul.	300
Feb.	1,100	Aug.	300
Mar.	1,200	Sep.	500
Apr.	1,100	Oct.	700
May	900	Nov.	800
June	300	Dec.	900

c. Average stay of migrants in county:
Out-migrants: 18 weeks
from June (mo.) through Sept. (mo.)
In-Migrants: 34 weeks
from Oct. (mo.) through May (mo.)

d. Source of information and/or basis of estimates: Clinics, Growers, County Agent's Office, Florida Employment Service, County Supt. of Public Instruction, Florida Industrial Commission Farm Labor Representative.

6. Housing accommodations for Martin County:

a. Camps

Maximum Capacity	Number	Occupancy(peak)
Less than 10 persons	0	0
10 - 25 persons	0	0
26 - 50 persons	2	77
51 - 100 persons	1	52
More than 100 persons	0	0

b. Other housing accommodations

Type	Number	Occupancy(peak)
Farms	0	0
Other locations	1	194

An undetermined number of migrants are housed in private homes in Booker Park, Pt. Salerno, Hobe Sound and Gomez.

c. Append map showing location of camps, roads, clinics, and other places important to project.

Map attached.

PRETEST DRAFT - 1967

Project No. MG 18F (68)
Date submitted May 9, 1968
MARTIN COUNTY

PART II - MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of Visits
	Total	Male	Female	
Total	371	162	209	549
Under 1 year	32	23	9	42
1 - 4 years	74	43	31	94
5 - 14 years	80	33	47	94
15 - 44 years	146	41	105	250
45 - 64 years	39	22	17	69
65 and older				

2. Patients hospitalized:

Age	Number of patients			Hosp. Days
	Total	Male	Female	
Total	19	6	13	164
Under 1 year	4	4		79
1 - 4 years	1		1	10
5 - 14 years	0	0	0	0
15 - 44 years	11	1	10	48
45 - 64 years	3	1	2	27
65 and older	0	0	0	0

3. Patients receiving dental services:

Item	Total	Under 15	15 and Older
a. Number of migrants examined: total	49	36	13
Number of decayed, missing, filled teeth			
Average DMF per person			
b. Individuals requiring services: total	45	34	11
Cases completed			
Cases partially completed	7	2	5
Cases not started			
c. Services provided: total			
Preventive			
Corrective	7	2	5
Extraction	6	1	5
Other			
d. Patient visits: total	62	39	23

4. Immunizations provided:

Type	Incomplete series	Completed immunizations - by age					Boosters, revaccinations
		Total	Under 1 year	1 - 4	5 - 14	15 and older	
All types	24	129		20	109		42
Smallpox		16			16		13
Diptheria	6	31		4	27		10
Pertussis	6	7		4	3		
Tetanus	6	31		4	27		10
Polio	6	33		4	29		9
Typhoid							
Measles		4		4			
Other (specify) Tine		7			7		

MARTIN COUNTY

5. Medical conditions found by physicians among outpatients, by age of patient:

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
I	Infective and parasitic dis.	47		19	3	20	5	
	Tuberculosis	1				1		
	Venereal Disease	20				15	5	
	Measles							
	Infestation with worms	26		19	3	4		
	Dermatophytosis & other infections of skin							
	Other							
II	Neoplasms	3			1	1	1	
	Malignant							
	Benign & unspecified	3			1	1	1	
III	Allergic, endocrine, metabolic, and nutritional dis.	1					1	
	Diabetes							
	Malnutrition							
	Other							
IV	Dis. of blood and blood-forming organs	1				1		
	Anemias	1				1		
	Other							
V	Mental, psychoneurotic and personality disorders							
VI	Dis. of nervous system and sense organs							
	Cerebro-vascular disease (stroke)	13	3	2	3	4	1	
	Eye Diseases	9	3	2	1	2	1	
	Dis. ear and mastoid pro.							
	Other dis. of nervous system	4			2	2		
VII	Dis. of circulatory system	30				11	19	
	Rheumatic fever							
	Diseases of the heart	1				1		
	Hypertension & other dis. circulatory system	29				10	19	
VIII	Dis. of respiratory system	93	16	27	23	21	6	
	Upper respiratory	55	16	15	7	12	5	
	Influenza and pneumonia							
	Bronchitis							
	Other	38		12	16	9	1	

5. Medical conditions found by physicians among outpatients, by age of patient (cont'd.):

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
IX	Digestive system diseases	21	4	7	3	5	2	
	Teeth and supporting structures							
	Gastroenteritis, colitis							
	Other	21	4	7	3	5	2	
X	Dis. of genito-urinary system	27			4	20	3	
	Urinary system diseases	3				2	1	
	Genital system diseases	24			4	18	2	
XI	Deliveries and complications of pregnancy							
	Complications of pregnancy							
	Deliveries							
	Compli. of puerperium							
XII	Skin diseases	76	7	19	26	19	5	
	Impetigo	76	7	19	26	19	5	
	Other							
XIII	Dis. of bones and organs of movement							
XIV	Congenital malformations	1		1				
XV	Dis. of early infancy							
XVI	Symptoms, ill-defined cond.							
XVII	Accidents, poisonings, violence							
	TOTAL OF CATEGORIES I-XVII	313	30	75	63	102	43	
SUPP	Special conditions, examinations, w/o sickness: total							
	Prenatal, postnatal care							
	Physical examinations							
	Immunizations							
	Surgical or medical after-care, follow-up							
	Fitting prosthetic devices							
	Other: Planned Parenthood	83				83		

PRETEST DRAFT - 1967

Project No. MG 18E (68)

Date submitted May 9, 1968

MARTIN COUNTY

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number	Services provided:	Number
a. Visits to homes	40	f. Health supervision, counselling, teaching, demonstrating care ~~in homes~~	130
b. Total households served	80	g. "Sick call" (nursing clinics)	30
c. Visits to schools, day care centers: total	45	h. Referrals for medical or dental care: total	16
d. Migrants presenting health record on request (PHS 3652)	5	Within area: total	13
		Number completed	13
e. Migrants given health record	0	Out of area: total	3
		Number completed	3
1B. Total No. individuals served	137	i. Other (specify)	

2. Sanitation services

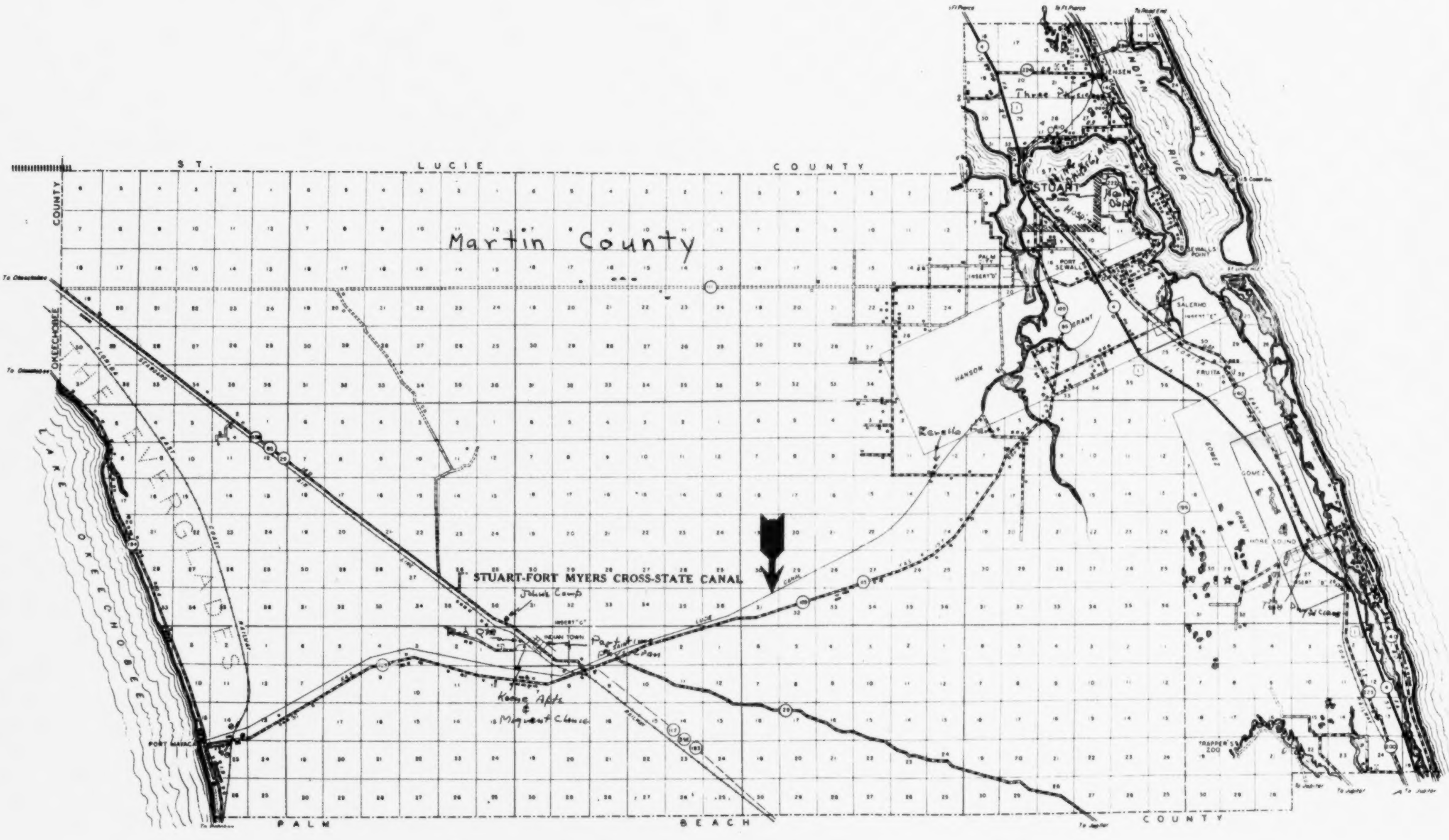
Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	3	0	1	1	194	0	0	0
Urban or other locations	See narrative on housing							

Table B. Inspection of living and working environment of migrants

	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	Since we did not have a migrant sanitarian employed all services were rendered by our staff sanitarians in the course of their routine work. Migrant Services were not segregated. All work was performed on a community basis.			
b. Sewage				
c. Garbage and refuse				
d. Housing				
e. Safety				
f. Food handling				
g. Insects and rodents				
h. Recreational facilities				
Working environment				
a. Water	No service performed in this area.			
b. Toilet facilities				
c. Other				

* Locations - camps or other locations where migrants work or are housed


ST. LUCIE COUNTY
Martin County
PALM BEACH COUNTY
OKEECHOBEE COUNTY
LAKE OKEECHOBEE
THE EVERGLADES
FLORIDA EAST COAST RAILWAY
STUART-FORT MYERS CROSS-STATE CANAL
LUCIE CANAL
John's Camp
INSERT "C"
INDIAN TOWN
Port
Kome Apts
&
Migrant Clinic
FORT MAYACA
To Okeechobee
To Jupiter
To Ft Pierce
To Road End
INDIAN RIVER
JENSEN
Three
RIO
STUART
Hosp
SEWALLS POINT
ST. LUCIE INLET
PALM CITY
INSERT "D"
PORT SEWALLS
SALERNO
INSERT "E"
GRANT
HANSON
FRUITA
GOMEZ
GOMEZ GRANT
HOBE SOUND
INSERT "B"
Zenetta
TRAPPER'S ZOO
U.S. Coast Gu.

MARTIN COUNTY MIGRANT HEALTH PROJECT

ANNUAL PROGRESS REPORT

May 1, 1967 thru April 30, 1968

Project objectives remain very much the same as last year:

1. To make comprehensive medical care available to the migrant population.
2. To make dental services, primarily emergency care, available to the migrant population.
3. To increase existing nursing services.
4. To upgrade the environmental health of the migrant population.

CHANGES IN MIGRANT SITUATION FROM PREVIOUS YEAR:

For the past two years the majority of our migrants have been of Mexican background who come from the western part of Texas and who return to Texas at the end of the season. This particular ethnic group bring their entire family with them and for that reason their age and sex composition are just what you would find in any community composed of families. They are of all ages - from infants to grandmothers. Most of the families have a greater number of children than the average American family. Relatively few of the Negroes in this county migrate as they did several years ago. This is probably due to the fact that there are now fewer seasonal crops and more year round work such as new citrus groves and flower farms.

These Spanish-speaking Texas migrants start coming into the county in October and the number keeps increasing until the peak is reached in March. Most of them live in the Keen Apartments which is a government subsidized concrete two-story building of ninety-eight units, containing from one to four rooms. Many of these units are leased by the Flavor-Pic Corporation to house their workers. This company has several large vegetable farms throughout this and Palm Beach County and transport these workers to wherever they have need for them. Other migrants live in relatively small camps. Some of these are located in the out-lying areas between Booker Park and the City of Stuart, the county seat, situated approximately 25 miles east of the Booker Park Section of Indiantown on Highway 76. Others are on Highway 710 going three miles North of Booker Park and five miles South of Booker Park. If these living quarters are at a particular grove or farm and there is sufficient work, the migrants will stay there as long as the work prevails; otherwise, they try to move in to the more populated areas such as Booker Park or Indiantown.

Occupants of these living quarters are entitled to nursing care as their needs arise. We have had no trouble getting them to come to medical clinics as long as they know what services are available to them and most of the growers in the area have been notified.

Several live in the main section of Indiantown where they rent individual homes and become out-migrants. These people go to Ohio, Indiana, and Michigan in the summer and return in the fall. There is a need for day care centers for pre-school children in this area. Very often all the adults in the family work and consequently the older children cannot attend school as they must stay home and care for the pre-school children. In some instances, an adult relative may care for several children who are related, as well as for her own. Occasionally a family will take infants in the fields with them, but this occurs less frequently each year. We have been trying to obtain some playground equipment for the children so they will be playing with something other than dirt and trash.

Another factor that has entered into the migrant picture is the Adult Education program. This was offered for the first time last year and 46 adult migrants attended school for ten weeks during the months of June, July, and August.

To achieve our objectives, a clinic was set up in the Booker Park section of Indiantown in the Keen Apartments. These apartments are the living quarters for the majority of our migrants. We have four rooms - one for the dental clinic, another for the medical clinic, a waiting room, dark room, and a room for general nursing procedures. The clinic is staffed by a part-time nurse and a part-time clerk, each working 20 hours a week. We also have three doctors; two from Stuart and one from Jensen Beach, who conduct the medical clinics. Two serve on alternating Monday nights and the other every third Wednesday. The dentist is from Stuart.

When the migrant population was low, as in June, July, August, and September, we held two medical clinics per month and as the number of migrants increased in November and December, we held three clinics per month. Start in January and continuing through April, we held four clinics a month. Often, due to the language barrier, we had trouble communicating with the patients but soon discovered some migrants who were willing to be interpreters and gradually most of the non-English speaking migrants would bring their own interpreters to clinic with them.

MARTIN CLINIC ATTENDANCE

Clinic Date	Type of Clinic	No. Pats.	Clinic Date	Type of Clinic	No. Pats.
6/05/67	Medical	19			
6/21/67	Medical	54			
7/03/67	Medical	25			
7/19/67	Medical	39			
8/07/67	Medical	23			
8/16/67	Medical	21			
9/11/67	Medical	19			
9/20/67	Medical	29			
10/02/67	Medical	26		No Dental Clinics held during 1967	
10/18/67	Medical	28			
11/06/67	Medical	17			
11/15/67	Medical	4			
11/29/67	Medical	4			
12/04/67	Medical	8			
12/11/67	Medical	11			
12/20/67	Medical	3			

Clinic Date	Type of Clinic	No. Pats.	Clinic Date	Type of Clinic	No. Pats.
1/03/68	Medical	16			
1/08/68	Medical	11			
1/17/68	Medical	9			
1/29/68	Medical	15			
2/05/68	Medical	20	2/06/68	Dental	8
2/12/68	Medical	18			
2/21/68	Medical	23	2/20/68	Dental	2
2/26/68	Medical	14	2/27/68	Dental	7
3/04/68	Medical	29	3/05/68	Dental	3
3/11/68	Medical	30	3/12/68	Dental	16
3/18/68	Medical	19	3/19/68	Dental	9
3/25/68	Medical	19	3/26/68	Dental	0
4/01/68	Medical	21	4/02/68	Dental	1
4/08/68	Medical	19	4/09/68	Dental	13
4/17/68	Medical	14	4/16/68	Dental	2
4/22/68	Medical	7	4/23/68	Dental	6

During the past year there were 32 medical clinic sessions conducted by a clinic physician held from 7:00 to 10:00 p.m. usually on Monday night. Serologies were done on all patients. A venereal disease investigator attended some of these clinics, interviewed all patients with a positive serology and helped to locate their contacts. A general serology survey was done in February at the farms where the migrants were employed. All patients with a positive serology who were in need of treatment were treated by a local physician who was paid on a fee-for-service basis.

A survey was also done for intestinal parasites in the schools and we found this to be a very rewarding project. Intestinal parasites and skin infections, commonly called "Florida Sores," were the two most frequently treated conditions in the clinics. These two conditions showed the desperate need for health education in the basic rules of cleanliness.

Migrant school children (along with others in their classes) were screened for Pediculosis. They were then referred to the doctor at the clinic for treatment. In the past this was a condition which was difficult to control.

Referrals have been made to the Cardiac Clinic, Tumor Clinic, Florida Crippled Children's Commission, etc. We have had some difficulty in getting the patients to follow through with these referrals even though transportation, etc. is provided for them. For example, a patient who attended one of the medical clinics was referred to the hospital for a G.I. Series, but two days later when it was arranged for him to have these x-rays, he felt better, went to work and could not be convinced that this particular examination was necessary.

Hospital Care: Both the medical staff and the hospital have been very cooperative and most people recognize the needs of the migrants. Payment for medical emergencies occurring between clinic sessions is arranged on a fee-for-service basis with local physicians and a flat rate charge is paid for out-patient emergency care at the local hospital.

Health Education is carried on in the school by the regular public health nurse and by the Project nurse at the clinic and in the homes. Many of the young adults are very responsive to suggestions and are very cooperative in helping with the older non-English speaking people. Even though many of these people are bi-lingual, many of them cannot read or write either language.

In-hospital care has recently been implemented and has worked well. Most of the hospitalized patients have been to the clinics and are known to the staff, a fact which is helpful in filling in the necessary forms. The main difficulty has been the time element in getting the information regarding an admission at the hospital to the project personnel.

Our Dental clinic did not start until February, 1968. The equipment was not as operational as we had expected it to be and for that reason this clinic got off to a slow start. The necessary repairs have now been made and things are going more smoothly. There have now been 11 dental clinic sessions at which a total of 49 patients were examined, 45 of whom required and received treatment. There seems to be relatively few major dental problems with this group of people, probably because the greater majority of them come from Texas where there is a high percentage of fluoride in the water. The dentist found a number of cases of mild fluoridosis at these clinics. Although the teeth are in fairly good condition, one frequent problem is pereodontitis which is due in part to poor oral hygiene and lack of dental care. The dental clinics are held every Tuesday night at the present time and are staffed by a dentist, a public health nurse, and a clerk-typist. Many of these people have never been to a dentist and it is difficult to convince them that they should have their teeth examined even though they are not aware of any trouble. We need to help them overcome their fear of coming in for dental care. We feel considerable education is needed in this field, and for this reason, arrangements have been made for a dental hygienist to visit the schools during the week of May 13. One of our first patients comes to each dental clinic and is helpful in interpreting and teaching the dentist Spanish phrases which are useful to him in exchanging information with the patients.

The response to the dental clinic has been poor in comparison to the medical clinics. However, through personal contact and with the help of notices sent home in Spanish and English through the schools, the number of patients is increasing. It seems that the migrant makes little effort and shows no interest in utilizing the limited services available to him outside the clinic. This points out the value of the dental program in the Migrant Health Project.

Relationship with Growers: We found the growers very cooperative and helpful in this area. This was proven conclusively when the serology survey was made.

Growers have been very helpful in telling the migrants of our facilities and services, and also in locating migrants for us when all we have is a name.

The local health department assists with their personnel whenever necessary. Services rendered by health department personnel involve many activities such as preschool clinics, immunization clinics, x-ray clinics, and venereal disease clinics. Health Department personnel take part in these activities. The venereal disease clinic is staffed by a practicing physician.

The Lion's Club assists financially with eye examinations and payment for glasses for the indigents and some migrants, but the service is very limited. Special health education programs are held throughout the year for all school pupils, including migrant school children.

The Soroptomist Club supplied all the waiting room furniture for the clinic as well as a refrigerator, desk, and typewriter and is willing to continue with this type of assistance.

General appraisal: We did not reach the degree of achievement for all of our objectives that we had hoped for. We are now more aware of the migrants' needs and will be more able to meet these needs in the future.

During the coming year we will:

1. Place more emphasis on health education.
2. Make certain every migrant is aware of the services available to him.
3. Improve our immunization program.
4. Constantly improve our method of keeping records.

NURSING

A public health nurse is employed for the project on a part-time basis the year round. She assists the physician and the dentist in their respective clinics. The day following the medical clinic, the nurse sees that all prescription medicines are received by the patient with detailed instructions.

Tuberculin tests were done on a group in which a case of tuberculosis was found and all positive tests were followed by a chest x-ray. One migrant was hospitalized in the Southeast Florida Tuberculosis Hospital.

When ordered by a physician we are able to distribute, at no cost, a considerable amount of canned prepared formula.

Patients who need special instructions in preparation of various x-rays have these interpreted for them by the nurse. Transportation was always provided where and when necessary.

For out-of-state referrals we use the regular Migrant Health Service Referral Forms and have found these to be most helpful and effectual.

There is an apparent need for more community participation.

GENERAL APPRAISAL OF NURSING PROGRAM

It is doubtful if nursing in this field of work is ever adequate. There is always much more that could be done and possibly should be done. Certainly this is true in Martin County. We have only one project nurse and she works 20 hours per week. She travels an average of 180 miles each week to and from the clinic and assists the physician and dentist at clinics seven hours each week. Records, of course, take up considerable time. This leaves little time for home visits, health education, etc. The nurse should have more time for immunization clinics for pre-school children, which would also involve contacting parents in regard to the importance of this protection. The immunization of the migrant school children is done at the schools by a public health nurse from the local health department.

The personnel of the public schools are most cooperative and helpful to us in any of our projects. They mimeograph any notices we want sent home with the children regarding our services and make every effort to see that these people respond.

It would probably be helpful if, in the future, we had a nurse whose home is in the same town as the clinic. It would certainly save considerable time and travel. Perhaps this will come to pass in the coming year.

SANITATION SERVICES

A full-time sanitarian was planned for this program; however, due to the shortage of sanitarians, we have been unable to employ anyone.

All services in the environmental health field rendered the migrant have been performed by the staff sanitarians in the course of their routine work. These services have been rendered as the occasion arose and have included routine investigations of nuisance complaints and animal bites. We have also performed services on a routine basis in the field of food service, rest room facilities, sewage disposal, water supplies, garbage and trash removal and housing accommodations.

In the course of our investigations we have observed that emphasis should be placed on the improvement of housing accommodations. There is a definite lack of suitable living quarters for local residents so one can imagine what would be available to anyone seeking housing accommodations for a short period of time.

We have noted that there is a gradual increase in the migrant population in the county as a whole, during November, December, and January when the out-migrants return from the trip north. We have also noted that we have a few in-migrants before January, but the number increases in February and reaches its peak in March. When the in-migrants arrive they must seek living accommodations in rooming houses, multiple family dwellings or in private homes. The majority of the rooming houses are sadly lacking in adequate toilet facilities and cooking facilities. They were built as cheaply as possible to provide protection from the weather with no concern for other comforts or conveniences.

Population Survey: In an attempt to arrive at a fairly accurate number of agricultural workers, we have contacted three reliable sources in the employment field. We first contacted the Florida Employment Office who referred us to the Florida Industrial Commission Farm Labor Office, who had the following to report: At the peak of the citrus harvesting season there were approximately 450 persons employed. During this same period of time there were 300 persons employed in vegetables. One other phase of agriculture that employs workers but had not been considered to date was the flower industry. It was estimated that during the peak of the season some 400 Mexicans and Puerto Ricans were employed.

We next contacted the county agent to discuss the migrant situation. He was of the opinion that there were approximately 1100 workers in agriculture at the peak of the season, with the majority of these living in the various communities, since they prefer to live in the populated areas rather than rural areas. Of this number, 300 were employed in the harvesting fo row crops. In addition to the workers in citrus and vegetables, we were informed that approximately 350 persons were employed in flower cultivation and cutting.

The center of population for the citrus and vegetable workers was the Booker Park section of Indiantown; however, a few workers live in Hobe Sound and Gomez. Apparently, not more than 100 workers live in Stuart. Many of the same people work both citrus and vegetables interchangeably depending upon the rate of pay and the volume of the product being harvested. It is common knowledge that vegetable harvesting pays more than citrus since the vegetables are more perishable and the quality of the product may be drastically altered by weather conditions. The vegetable grower must pay a premium price in many instances in an effort to protect his investment, consequently citrus harvesting suffers.

The workers in the flower farms are in most instances of Spanish speaking descent being Mexicans or Puerto Ricans. Very few are from other racial groups, either White or Colored. These people live primarily in the Port Salerno area with possibly a few living in Gomez.

To complete our survey we find that an undetermined number of workers primarily in citrus and vegetables, who were included in the estimated total, commute from Okeechobee and Fort Pierce each day.

Housing: We have surveyed the so-called labor camps in the Indiantown area in an effort to ascertain the number of occupants and occupancy trends. Of the four locations involved, we noted that the population was generally very fluid with a constant change of room occupancy. At the first place visited, John's Camp, we counted 26 rooms with a possible population of 52 men, women, and children. At the Zarella Farm, located midway between Stuart and Indiantown, there were 25 rooms for migrants available. The remainder of the housing units were for permanent employees. The migrants were all Puerto Ricans.

Another housing facility visited is known as the Red Quarters. This establishment consisted of 20 rooms with a total population of 30 men, women and children.

By far the best facility available for occupancy, either on a short time or yearly basis, is the Keen Apartments. This is a 98 unit building of masonry construction that was built with a Federal guaranteed loan to alleviate the housing shortage of the area. The building is occupied by approximately 200 persons at the peak of the season. These may be single males who live two to a room or females who occupy the one bedroom, living room and kitchen efficiency units. All units have bathrooms convenient or connected. Unfortunately the facilities provided are not always appreciated since there is a constant problem of maintenance due to wanton vandalism.

PROJECT OBJECTIVES

During the coming year we have the following objectives:

1. Improve sanitation in child care.
    A. Contact all persons caring for children and explain the program.
    B. Supervise structural changes in buildings, including installation of adequate toilet facilities.
    C. Supervise food service with particular emphasis on food preparation, storage, and sanitizing of utensils.
2. Conduct sanitary surveys of all rental housing, especially rooming houses

and multiple dwelling units.

A. Contact owners to discuss structural deficiencies and make recommendations for their correction.

B. Determine responsibility for maintenance of plumbing, cleanliness and garbage disposal.

C. Make repeat visits as often as necessary to assure cooperation.

3. Garbage and trash disposal surveys to be made on an on-going basis.

A. Contact occupant of buildings if yard is littered with waste.

B. Contact owners of commercial establishments if containers are inadequate.

C. Explain need for clean surroundings and request cooperation in maintaining clean premises from insect and rodent standpoint.

D. Contact collection service to arrive at a workable solution if complications arise over collection.

4. Rodent and insect control.

There has been a great need for a control program of this nature for some time. A limited abount of work has been done by the sanitarians primarily in food service and food outlet establishments. A comprehensive survey is needed in the commercial areas and multiple dwelling units immediately. After the scope of the project is established, an extermination program for rodents should be undertaken. As the infestation declines in commercial buildings, the survey and extermination work should be expanded into residential areas, especially where substandard housing exists. The success of this project will largely depond upon close follow-up work. As extermination begins, the animals have a tendency to scatter and would, no doubt, invade any untreated structure in the area. With the joint undertaking of garbage and trash removal and rodent extermination, there would no doubt be a noticable decline in both insect and rodent population.

We are well aware that the proposed program will require untiring efforts and patients since educational programs tend to be rather slow in accomplishing their goals.

ORANGE COUNTY HEALTH DEPARTMENT

Wilfred N. Sisk, M. D., Director

Area of County: 916 square miles

Resident Population: 297,000

Migrant Health Project Staff:
- 2 Public Health Nurses
- 1 Public Health Nurse Part-Time
- 1 Senior Sanitarian
- 1 Clerk-Typist
- 1 Clinic Aide

PRETEST DRAFT - 1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT

For May 1, 1967 through April 30, 1968

Date submitted May 27, 1968

PART I - GENERAL PROJECT INFORMATION

1. Project Title

A Program to Develop a Statewide Program of Health Services for Migrant Farm Workers and Their Dependents in Florida.

2. Grant Number (use number shown on approved application)

MG-18E (68)

3. Name and Address of Applicant Organization

Orange County Health Department
Post Office Box 3187
Orlando, Florida 32802

4. Project Director

Wilfred N. Sisk, M.D., Director
Orange County Health Department
Post Office Box 3187
Orlando, Florida 32802

5. Population Data - Number of Migrants (workers & dependents) for Orange County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	9000	4900	4100
Under 1 year	125	72	53
1 - 4 years	900	460	440
5 - 14 years	1300	700	600
15 - 44 years	4100	2850	1250
45 - 64 years	1600	950	650
65 and older	425	260	165
2. In-migrants			
Total	3000	1700	1300
Under 1 year	50	35	15
1 - 4 years	250	150	100
5 - 14 years	400	220	180
15 - 44 years	1450	1025	425
45 - 64 years	725	480	245
65 and older	200	138	62

b. Number of migrants by month:

Month	Total	Month	Total
Jan.	8000	Jul.	600
Feb.	7300	Aug.	550
Mar.	4550	Sep.	1000
Apr.	4200	Oct.	5000
May	3900	Nov.	6500
June	3000	Dec.	8200

c. Average stay of migrants in county:

Out-migrants: 21 weeks

from Nov. (mo.) through May (mo.)

In-Migrants: 40 weeks

from Sept. (mo.) through June (mo.)

d. Source of information and/or basis of estimates:

6. Housing accommodations for Orange County:

a. Camps

Maximum Capacity	Number	Occupancy(peak)
less than 10 persons		
10 - 25 persons		
26 - 50 persons	3	90
51 - 100 persons	2	120
More than 100 persons	3	975

b. Other housing accommodations

Type	Number	Occupancy(peak)
Farms		
Other locations		
Homes	1900	7300
Rooming Houses	125	1150

c. Append map showing location of camps, roads, clinics, and other places important to project.

Attached

PRETEST DRAFT - 1967

Project No. MG-18E (68)
Date submitted May 27, 1968

ORANGE COUNTY

PART II - MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of Visits
	Total	Male	Female	
Total	1121	350	771	3345
Under 1 year	196	104	92	396
1 - 4 years	152	71	81	269
5 - 14 years	149	76	73	287
15 - 44 years	551	71	480	2259
45 - 64 years	73	28	45	134
65 and older				

2. Patients hospitalized:

Age	Number of patients			Hosp. Days
	Total	Male	Female	
Total	172	4	168	683
Under 1 year	1		1	21
1 - 4 years	1	1		14
5 - 14 years				
15 - 44 years	5	1	4	45
45 - 64 years	165	2	163	603
65 and older				

3. Patients receiving dental services:

Item	Total	Under 15	15 and Older
a. Number of migrants examined: total	79	75	4
Number of decayed, missing, filled teeth	385	375	10
Average DMF per person	5	5	5
b. Individuals requiring services: total	79	75	4
Cases completed	40	36	4
Cases partially completed	18	18	0
Cases not started	21	21	0
c. Services provided: total	450	432	18
Preventive	32	28	4
Corrective	277	269	8
Extraction	141	135	6
Other			
d. Patient visits: total	238	231	7
e. Health Ed. (Films & Lectures in Schools)	40		

4. Immunizations provided:

Type	Incomplete series	Completed immunizations - by age					Boosters, revaccinations
		Total	Under 1 year	1 - 4	5 - 14	15 and older	
All types	260	2150	237	462	294		1157
Smallpox		116	4	60	29		23
Diptheria	67	480	54	57	71		298
Pertussis	54	279	54	52	23		150
Tetanus	67	489	54	57	74		304
Polio	47	458	62	88	46		262
Typhoid	25	168	2	25	21		120
Measles		160	7	123	30		
Other (specify)							

5. Medical conditions found by physicians among outpatients, by age of patient:

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
I	Infective and parasitic dis.	256	19	53	72	92	20	
	Tuberculosis	100	1	13	51	22	13	
	Venereal Disease	67	1		2	58	6	
	Measles							
	Infestation with worms	89	17	40	19	12	1	
	Dermatophytosis & other infections of skin							
	Other							
II	Neoplasms							
	Malignant							
	Benign & unspecified							
III	Allergic, endocrine, metabolic, and nutritional dis.	8	1		1	3	3	
	Diabetes	3					3	
	Malnutrition							
	Other - Allergy	5	1		1	3		
IV	Dis. of blood and blood-forming organs	41	2	10	13	10	6	
	Anemias	41	2	10	13	10	6	
	Other							
V	Mental, psychoneurotic and personality disorders	47	1	1	4	28	13	
VI	Dis. of nervous system and sense organs	70	7	7	33	20	3	
	Cerebro-vascular disease (stroke)							
	Eye Diseases	35	4	2	14	12	3	
	Dis. ear and mastoid pro. & (Nose & Throat)	35	3	5	19	8		
	Other dis. of nervous system							
VII	Dis. of circulatory system	65			3	36	26	
	Rheumatic fever	1			1			
	Diseases of the heart	54			1	29	24	
	Hypertension & other dis. circulatory system	10			1	7	2	
VIII	Dis. of respiratory system	175	37	40	38	55	5	
	Upper respiratory	142	35	38	36	29	4	
	Influenza and pneumonia	1				1		
	Bronchitis							
	Other - Asthma	32	2	2	2	25	1	

5. Medical conditions found by physicians among outpatients, by age of patient (cont'd.):

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
IX	Digestive system diseases	47	8	4	7	19	9	
	Teeth and supporting structures	3			3			
	Gastroenteritis, colitis	44	8	4	4	19	9	
	Other	18	2	5	4	5	2	
X	Dis. of genito-urinary system	18	2	5	4	5	2	
	Urinary system diseases							
	Genital system diseases							
XI	Deliveries and complications of pregnancy							
	Complications of pregnancy							
	Deliveries							
	Compli. of puerperium							
XII	Skin diseases	113	15	35	33	18	12	
	Impetigo							
	Other							
XIII	Dis. of bones and organs of movement							
XIV	Congenital malformations							
XV	Dis. of early infancy							
XVI	Symptoms, ill-defined cond.							
XVII	Accidents, poisonings, violence	12		1	7	3	1	
	TOTAL OF CATEGORIES I-XVII	852	92	156	215	289	100	
SUPP	Special conditions, examinations, w/o sickness: total							
	Prenatal, postnatal care	905			14	891		
	Physical examinations							
	Immunizations							
	Surgical or medical after-care, follow-up							
	Fitting prosthetic devices							
	Other - Child Health Services	699	307	229	149	14		
	Family Planning	1017				1016	1	

PRETEST DRAFT - 1967

Project No. MG-18E (68)

Date submitted May 27, 1968

ORANGE COUNTY

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number
a. Visits to homes	900
b. Total households served	1246
c. Visits to schools, day care centers: total	90
d. Migrants presenting health record on request (PHS 3652)	225
e. Migrants given health record	1179
b.(1) Individuals Served (Home Nursing Visits)	2356

Services provided:	Number
f. Health supervision, counselling, teaching, demonstrating care in homes	100
g. "Sick call" (nursing clinics)	
h. Referrals for medical or dental care: total	51
Within area: total	49
Number completed	49
Out of area: total	2
Number completed	2
i. Other (specify)	

2. Sanitation services

Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	12	7	210	210	725	16	16	450
Urban or other locations								

Table B. Inspection of living and working environment of migrants

	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	10*	54	19	17
b. Sewage	10	57	17	17
c. Garbage and refuse	10	225	143	127
d. Housing	10	51	38	13
e. Safety	10	84	19	19
f. Food handling	10	529	Various	Various
g. Insects and rodents	10	185	128	76
h. Recreational facilities	10	35	5	3
Working environment				
a. Water	17	57	7	7
b. Toilet facilities	14	39	12	5
c. Other				

* Locations - camps or other locations where migrants work or are housed

*There are 10 camps and areas in the county.

WINTER GARDEN
(West Section of County)
CLINIC SCHEDULE

HEALTH CENTER			
Every Monday	Immunizations	8:00 - 4:30	1st
	General Clinic		
	Parasite Control		
	Child Health Conference		
	Maternity	8:00 - 12:00	2nd
	Family Planning (ICUD & Oral)	1:00 - 4:30	3rd
	New Maternity		
Health Center			
Every Tuesday	General Clinic	8:00 - 12:00	
	New Maternity		
	Immunization		
	Venereal Disease Clinic		
	Child Health Conference (Phys. Exam. School Children)		
	Conference (Mental Health Patient by Physician)		
Health Center			
Every Tuesday	Migrant Morbidity	1:00 - 4:30 (Winter - Session Continues later)	
Health Center			
Every Wednesday	Tuberculosis Clinic	9:00 - 12:00	
	New Maternity		
	Immunization		
Health Center			
Thursday (1 x monthly)	Family Planning (IUCD & Oral)	6:00 - 9:00 p.m.	
Tildenville			
Thursday (1 x monthly)	Immunization	10:30 - 12:00	
Oakland			
Thursday (2 x monthly)	Immunization	8:00 - 12:00	
Baptist Church			
Friday (1 x monthly)	Immunization	9:00 - 12:00	

WINTER GARDEN CLINIC SCHEDULE - Continued

Ocoee Deneef Camp Wednesday (2 x monthly)	Immunization	9:00 - 11:00
Ocoee Women's Club Wednesday (1 x monthly)	Immunization	9:00 - 11:00

APOPKA
(Northwest Section)
CLINIC SCHEDULE

Health Center Every Monday	General Clinic	8:00 - 4:30
	Parasite Control	
	New Maternity	
	Immunization	
	Tuberculosis Clinic	8:00 - 11:00
	Child Health Conference	1:00 - 4:00
Health Center Every Tuesday	Maternity Clinic	8:00 - 12:00
	Family Planning (IUCD & Oral)	
	Child Health Conference	1:00 - 4:30
	Immunization	
	Venereal Disease Clinic	
Health Center Every Thursday	Migrant Morbidity	8:00 - 12:00
Zellwood Wednesday (1 x monthly)	Immunization	9:00 - 12:00
Plymouth Wednesday (1 x monthly)	Immunization	9:00 - 12:00
Lockhart Thursday (1 x monthly)	Immunization	9:00 - 12:00

ORLANDO

Central Every Thursday)	Family Planning (IUCD)	6:00 - 9:00 p.m.

ANNUAL PROGRESS REPORT
MIGRANT HEALTH PROJECT
ORANGE COUNTY

Period Covered: May 1, 1967 - April 30, 1968

The Project objective of the past year was to improve our services to the migrant families with greater emphasis and follow-up on family planning, maternity care, health hygiene, and to place more emphasis on immunization; including measles vaccine.

During the past year we feel we have met the Project's objectives. Our progress in the field of migrant health has been evidenced in part by the fact that our migrant families are more aware of the medical and clinic services available. Efforts on the part of migrant personnel to render health care were stepped up considerably during the 1967-68 year. Approximately 3,345 migrants have received health, medical, and dental services - excluding those seen in the immunization clinics. An increase of 30 per cent in the number of home visits was accomplished by the public health nurse.

Objectives for 1967-78

1. To provide more medical services for migrants and their families.
2. To increase dental services for migrants and their families.
3. To motivate the agricultural workers to improve their environment and health habits.
4. To continue to improve the environmental health aspects of the migrants' environment.
5. To improve the medical and clinic services already in operation thus enabling nurses the opportunity for more individual counseling.
6. To encourage better attendance in family planning (child spacing), maternity, and child health clinics.
7. To obtain the services of another physician for child health clinics.
8. To increase the number of home visits to determine the health needs of the migrants and make known to them the medical and other community resources available to meet their needs.
9. To extend the use of the referral system and standardization of reports, records, and communications.
10. To cooperate with volunteers, migrant teacher aides, migrant ministry, Vista, and other interested groups to inform the general public of the migrant problems and encourage groups to assist where needed.
11. To extend family planning evening clinics to include other services; such as immunizations, screening for intestinal parasites, tuberculosis, etc.

12. To refer patients for hospital care and outpatient services.

13. To increase community action to start more day care centers for the migrant children.

Agricultural Migrant Situation in the Project Area

The population of the migrant workers is 11,400 including dependents and local workers conforming to migrant criteria.

Most of our migrant families live in the small communities in the northwest and west sections of Orange County. Many families stay in the area all year with one or more members going North during the summer. The migrants begin to arrive in Orange County in September, although the majority arrive in November during the citrus season. The majority of the migrant population are Negroes who work as fruit pickers. The second largest number of migrants are Anglos. The number of Mexican-Spanish speaking migrants increased during the last year. There was an increase in migrants from Arkansas, Missouri, and Texas. The majority of the migrants leaving Orange County go to Virginia, Maryland, New York, and Washington.

Medical and Dental Services

During the past year we have increased our clinic and medical services. Family planning clinics are held weekly in the migrant areas. Two new family planning evening clinics were started in the Apopka and Winter Garden areas. We have added a tuberculosis clinic in the Winter Garden area and continue to have one tuberculosis clinic a week in Apopka. The tuberculosis control physician and a migrant public health nurse attend each clinic. The physician examines the patients, diagnoses for tuberculosis, and prescribes drugs. PPD skin testing, screening, and follow-up of contacts is done. Patient response to these clinics has been very good.

During the past year the migrant nurses in the Winter Garden area contacted two local companies and worked with the assistance of ten crew leaders. The migrants had PPD skin tests and x-rays. Three active cases of tuberculosis were discovered as a result of this survey. A mobile x-ray unit is now scheduled in these areas three days a month.

Tuberculin skin testing was given to the school children in the first and sixth grades of the schools in the migrant areas. Seven hundred and twelve (712) children were tested.

Information sheets on the location and time for clinic services are given to the school principals in outlying areas for distribution to migrant families at the time of school registration.

The Zellwood evening clinic has been transferred to the health center in Apopka. (The clinic attendance had declined due to families moving to a larger community and to machines taking the place of workers on the Zellwood farms.) Since the clinic has been transferred, the attendance has increased.

The Venereal Disease Control Division contacted four companies and three labor camps for surveys conducted both in the daytime and evening hours. Over 800 bloods were drawn and 22 cases of syphilis were diagnosed.

The Mobile Dental Unit is available in the Apopka office one afternoon each month for dental care.

Four community health workers, supervised by a public health nurse, completed the census tract survey in the migrant areas of Apopka and Winter Garden and referred the entire families to the immunization clinics. As a result of this survey, a larger number of migrants attended these clinics.

Plans are in the making for a mass measles immunization program to be started in all schools in migrant areas in May, 1968.

This past year we had a Maternal and Infant Care Project in Orange County. A physician, who is the obstetrics consultant on this project, attends the two weekly maternity clinics in the migrant areas. The migrant maternity patients are receiving better maternity care in these clinics. When total care is recommended, the Maternal and Infant Care Project will pay the hospital bill. Nurses are making more field visits and are referring maternity patients to the family planning clinics and the new-born infants to the well baby clinics.

The Headstart Program has contributed to meeting some of the needs of the migrants. They have established one day care center in the Winter Garden area.

Clinic attendance has increased in both the Winter Garden and Apopka areas. Five public health nurses (including two migrant nurses), a migrant clinic aide, and a clerk staff the clinic in the Winter Garden area. In the Apopka center, four public health nurses (including one migrant nurse), a migrant clinic aide, and a clerk staff the clinics.

The Migrant Morbidity Clinics in Winter Garden and Apopka are open all year for the migrant families who depend on this service.

A retired physician continues to treat the migrant patients in the morbidity clinics. He does an excellent job and has established a very good rapport with the migrants. He speaks Spanish which has been advantageous to our Spanish speaking migrants. Physicians from a local hospital, the assistant health officer, and a gynecologist assist in the other clinics. The gynecologist is a consultant to the other physicians in the Maternity and Family Planning Clinics.

Additional space has been obtained in the Apopka Health Center for enlarging the clinic areas. Due to the increase in family planning, child health services, and other services, this space was needed and will be remodeled for use in the coming year.

There is a need for another physician for well baby and child health conferences in the Apopka and Winter Garden area.

Hospital care and outpatient service is now available to the migrants in Orange County.

NURSING SERVICE

STAFF PERSONNEL - see next page.

STAFF PERSONNEL

Public Health Nurses	(3)	100% time
Public Health Nurses (on generalized program but their work is predominately in migrant areas. They assist in all the clinics in these areas.)	(5)	50% time
Public Health Nursing Supervisor	(1)	40% time
Clerk-Typist II	(1)	100% time
Clinic Aide	(1)	100% time

All the public health nurses working in the migrant areas have done an excellent job. The clinic attendance has increased, partly as a result of more home visits. Due to the resignation of one of our migrant project nurses, it was necessary to transfer another nurse from our staff to the Migrant Health Project. She has demonstrated her ability to continue the rapport established with the migrant workers.

Our migrant nurses have very good rapport with the crew leaders who cooperate by transporting patients from the fields to keep clinic appointments.

They have good cooperation with the migrant ministry. Volunteers have assisted in the clinics and refer patients to the clinics. Vista workers also have established good rapport and are very helpful in assisting the nurses to help solve the patients' needs.

The migrant patients attend all of our regular clinics available in the areas and are treated as any other patient from this community. This enables the migrant patients to feel a part of the total community and does away with the stigma of being labeled a "migrant."

We are using the Migrant Service Referral Form and have had success with approximately 75 per cent of these referrals. Family Planning referrals were very adequate. At least 25 per cent of the incomplete referrals are the result of the patient going to another location instead of to the one on the referral.

We feel that progress is being made by the public health nurses, teacher aides in the schools, Vista workers, migrant ministry, and other interested organizations, to involve community groups in planning and sharing resources for the migrants.

As part of the health education program next year, plans are to emphasize the need for day care centers. At the present time, an older child stays home from school to take care of the younger children.

The health education services to the migrant population is largely given by the public health nursing staff, using leaflets, diagrams and audio-visual aids for relating facts about nutrition, planned parenthood, good health and hygiene habits, communicable disease control, prenatal care, infant care and immunizations during home and office and clinic visits. Each individual family seen in the clinics is interviewed by a public health nurse and counseled on their specific problems.

Added to our health education services this past year are classes during Maternity and Family Planning Clinics. Visual aids, film strips, etc., are used. The classes are on mother-baby care, family planning, good health habits, and accident prevention. The patients have displayed interest and are entering into discussion and question periods.

Our migrant nurses attended workshops and participated in instructing the migrant teacher-aides about the medical and clinic services available for the migrants. The teacher-aides are working in the schools and contributing a great deal to improve the migrant needs.

The health educator, a R.N. on the Maternal and Infant Care Program, began teaching classes in the Maternity and Family Planning Clinics in March, 1968, and relieved a public health nurse for other duties.

The nurses on the Migrant Health Project have assisted the two Vista workers (one being an R.N.) in the Winter Garden area to plan and teach classes in the migrant areas on nutrition, safety, good health habits and sex education.

One of our local television stations ran a series of interviews with some of the migrant families and presented a one-hour film on the Migrant Health Program with pictures of labor camps, the clinics, and a physician and public health nurse interviewing the patients. This movie was shown twice, and as a result, clinic attendance increased.

MEDICAL AND NURSING

May 1, 1967 through April 30, 1968

FAMILY HEALTH SERVICES

Type of Clinic	Number of Sessions	House of Clinics		Patient Visits
		M.D.	PHN	
Morbidity, General Clinics, i.e. Maternity, TBC, V.D., Family Planning, Child Health Conferences, etc.	253	952	6,259	3,345*
Immunization Clinics	211			2,666
Total	464			6,011

* Total number of patients seen by nurse only	376
Total number of patients seen by nurse and physician	2,969
	3,345

Each individual seen in the general and morbidity clinics was interviewed by the public health nurse and counseled on his/her specific problem at the time of the visit.

CONDITION	TOTAL	SEX	AGE GROUP					ETHNIC GROUP			
			=1	1-4	5-14	15-44	45+	Negro	P.R.	Mexican	Anglo
ANEMIA	12	M	2	4	4	1	1	6		1	5
	29	F		6	9	9	5	10		2	17
ALLERGY	0	M									
	5	F	1		1	3		3		1	1
ARTHRITIS	5	M				5					5
	7	F				7		1			6
ASTHMA	4	M		1	1	1	1			1	3
	28	F	2	1	1	24		10			18
CARDIO-VASCULAR DISEASE	6	M				3	3	2			4
	48	F			1	26	21	30	3	15	
HYPERTENSION	1	M				1					1
	9	F				7	2	3		5	1
CHILD HEALTH SERVICES	349	M	172	102	72	3		147	3	28	171
	350	F	135	127	77	11		186		10	154
CHILD SPACING	0	M									
	1017	F				1016	1	608	4	23	382
DENTAL	2	M			2			1			1
	1	F			1						1

CONDITION	TOTAL	SEX	AGE GROUP					ETHNIC GROUP			
			-1	1-4	5-14	15-44	45+	Negro	P.R.	Mexican	Anglo
DIABETES	1	M					1				1
	2	F					2	1			1
EAR, NOSE & THROAT	17	M	3	3	10	11		5	1	6	5
	18	F		2	9	7		4	1	1	12
EPILEPSY	2	M			1	1		2			
	0	F									
EYE	14	M	3	1	8		2	4		4	6
	21	F	1	1	6	12	1	7			14
GASTRO-INTEST.	13	M	4	3	3	3		7		3	3
	31	F	4	1	1	16	9	16	3		12
GENITO-URINARY	6	M		3	1	2		2		1	3
	12	F	2	2	3	3	2	2		3	7
GYN.		M									
	23	F			1	19	3	5		3	15
INTEST. PARASITES	39	M	5	17	11	5	1	16			23
	46	F	12	19	8	7		20	4		22
MATERNITY		M									
	905	F			14	891		458	3	38	406
NEGATIVE FINDINGS	6	M	2	1	2	1		4			2
	6	F	1			5		1			5

CONDITION	TOTAL	SEX	AGE GROUP					ETHNIC GROUP			
			-1	1-4	5-14	15-44	45+	Negro	P.R.	Mexican	Anglo
NEURO, NERV. TENSION	2	M			1	1					2
	16	F	1		1	11	3	3			13
ORTHOPEDIC	4	M		1	2		1	2	1		1
	6	F	1	-	-	5	-	2	-		4
PNEUMONIA	0	M									
	1	F				1					1
SKIN	44	M	5	13	14	5	7	11		6	27
	69	F	10	22	19	13	5	35	1	2	31
TRAUMA	4	M			3	1					4
	8	F		1	4	2	1	4			4
T.B.	46	M	1	6	23	9	7	33			13
	54	F		7	28	13	6	40		3	11
TUMOR	0	M									
	2	F		1	1						2
U.R.I.	55	M	15	17	15	7	1	20	4	5	26
	87	F	20	21	21	22	3	30		5	52
VENEREAL DISEASE	51	M			2	43	6	39	7	3	2
	16	F	1		15		12				4

SANITATION

I. General description of sanitation services.

A. One sanitarian spends full time on general sanitation work in the migrant labor camps. Several sanitarians in the Orange County Health Department spend a percentage of their time on the various facets of environmental health work in the areas in which the migrant people locate their own housing.

1. The camp owners are very cooperative in maintaining general sanitation conditions, such as sewage and water, by hiring professional sewer and water plant operators to maintain the proper operation in the camps.

2. Among those involved in labor camp conditions are various other government agencies, various church organizations, local growers and other local community groups. All Orange County Health Department sanitarians involved in general sanitation work in areas of the county where migrant families live, in housing that is rented outside the labor camps, make periodic inspections of the various public and private businesses that involve migratory labor. Complaints received by the health department from the community as a whole, health nurses, medical doctors, ministers, and other concerned individuals, are followed-up by the sanitarians. This is to remedy situations and to educate the migrant in the proper method of eliminating the complaint by correction of the problem or improving the living conditions.

B. The specific duty and objective is to continue to improve the sanitary facilities in the migrant labor camps and in the migrant labor community at large. This includes protection of water supplies, disposal of waste, garbage disposal, safety and general housing conditions. These can be accomplished by:

1. Stricter enforcement of the camp regulations;

2. Through encouragement of growers to provide better housing, transportation and general field sanitation.

C. Educational work in the existing camps was done by the sanitarian, the crew leaders, camp owners, individual migrants and other disciplines in the field. This was done on specific items which resulted from discrepancies noted on periodic inspections, new camps being built, enlargement of existing camp facilities, changes in camps from individual to family type living, etc.

D. Relationships were established by conferences between the project sanitarian, and camp owners, growers, camp managers, and other people concerned with the camps on the following subjects:

1. Sanitary facilities,

2. Shelter,

3. Fire protection,

4. Plumbing,

5. Water supply,

6. Sewage disposal,

7. General camp site.

New problems presented to the camps, to the sanitarian, and other involved personnel in the past year are problems growing out of the change from barracks-type living quarters for single men to family-type living quarters. This is creating problems in safety (especially for children), need for child care facilities, and other problems concerning family life living.

Much work has been accomplished this past year in converting the camps from barracks into two and three bedroom apartments for family units. In Orange County all camps but one company owned camp have been converted to apartment complexes.

Many working agreements were reached this past year with the following groups and the chain of communication has been much improved:

1. Office of Economic Opportunity and Head Start Program;

2. Florida Hotel and Restaurant Commission;

3. Orange County Planning Board;

4. Local Fire Departments and State Fire Marshall.

Joint cooperation of the health department and the OEO has resulted in progress being made, especially with the Head Start Program. Several Head Start Programs are convenient to, or adjacent to, the migrant labor camps.

Discussion and coordination of joint efforts with the Florida Hotel and Restaurant Commission upgraded conditions by enforcement of prescribed standards in dwelling units that may come under their supervision.

The Orange County Building and Zoning Department of the Planning Board cooperated in the development of rules and criteria for the improvement of migrant sanitation and living conditions as it pertains to structural details of housing, plumping, zoning, electrical and other basic requirements.

Joint pre-licensing of camps with the local Fire Department and State Fire Marshall aided with recommendations and continuing advice to migrant camp owners.

Farm labor representatives, the Farmers Home Administration, and churches have all been instrumental in providing information and services, orientation and in-service training of staff, attendance at health conferences on migrant health and related problems. These representatives and the project sanitarian attended joint migrant-oriented meetings on convention level and periodic general sanitation staff meetings in the health department where problems relating to general sanitation were discussed.

E. The above groups mentioned in paragraph "D" are the type and source of consultation obtained from outside the migrant project. They have been very cooperative in offering assistance in the migrant program and have asked our assistance in presenting some of the problems to the general community. We will, of course, cooperate to the fullest extent in all the endeavors of these various groups.

F. Consultation is needed and will continue to be needed from all governmental and civic groups and is welcomed at any time.

II. General description and condition of housing accommodations for migrants was vividly portrayed in two very good documentary films presented by a local television station and rerun several times by them this past year. These films showed the general conditions and problems existing in the migrant labor population in the Orange County area. These programs were very objective and presented a true picture of migrant living to concerned individuals and groups. Our own medical, nursing, and sanitation staff were very active in these films and a true picture of camp living and clinics was presented. These films have been instrumental in arousing new interest on the part of various civic groups. We hope that films of this type will cause more people to volunteer to aid our migrant health efforts.

A. In Orange County there are eight licensed migrant labor camps. The maximum capacity of these labor camps is approximately 1,125 people. One of our larger camps is the Harlem Heights Camp located in the Winter Garden area. Present occupancy consists of single males and families. Within the past three years, 57 per cent of these barracks have been converted to two and three bedroom apartments to accommodate the trend for family units. Single men prefer to rent with two or three other men in an apartment rather than live in a barracks with possibly 60 men. This trend has caused the owner of this particular camp to convert completely to apartments and this construction phase should be completed during this summer season. These changes require that the sanitarian spend a great deal of time with the camp owner in discussion the needs of the migrant and following local ordinances and the Florida State Sanitary Code in relation to requirements of labor camps.

Reddick's Labor Camp is located in this same area and has a capacity of 325 people. This camp also consists of single males in barracks and family apartment units. Again the trend has been away from the barracks unit to the apartment.

Granada Labor Camp is located in the Windermere area and is owned by Minute Maid Company. This particular camp has a capacity of 294 people and is occupied 100 per cent by single males. These men are periodically moved from area to area within the state where Minute Made has groves and other labor camps are located. This camp will remain as a barracks type operation.

Islesworth Labor Camp has a capacity of 75 people and since "off-shore labor" has not been used for some time, several of the houses have been used for permanent employees and their families.

Zellwood Labor Camp has a capacity of 25 people. This again is a labor camp that was converted this past year from a barracks type operation with the capacity of approximately 80 people to apartments with a capacity of 25.

De Nees' Labor Camp has a capacity of approximately 50 to 75. It was not licensed this past year but will be relicensed for this coming year. There are some basic sanitation problems and upgrading of housing required to be done before this camp meets the requirements to be licensed by the State of Florida. These problems needing improvement are basic sewage disposal, chlorination of water supplies, rodent problems and sub-standard housing. When this camp is relicensed it will be 100 per cent family occupancy with a group of approximately 12 apartments and small houses.

Libby, McNeil and Libby Labor Camp has a capacity of 35 people. The present occupancy is mostly families and this camp is located on 880 acres owned by the company in the Zellwood area. It consists of one large house and three smaller houses. The Libby Company Camp was just given approval to operate for a trial period of two years by the Orange County Commission. The camp is necessary as Libby was unable to find local housing for their labor in the existing labor camps. The present buildings are being used for housing for the remainder of the season but if this complex is to be used as a labor camp during the coming year, many changes must be made to the present facilities. Preferably, new buildings would be constructed which would be better suited for migrants and of a more permanent nature. Considerable time was spent by the sanitarian in assisting the Libby Company in getting approval from the Orange County Commission for a labor camp in this area. The project sanitarian has spent much time with the Libby Company representatives in discussing the necessary requirements for this camp to meet the State requirements for licensing. Time was spent also for planning a new facility, which is the preferred alternative by the State Board of Health.

The above named camps, with the exceptions mentioned, all meet the State requirements and are of standard concrete block construction. They all contain modern sanitation facilities, sanitary kitchen facilities in a common kitchen area, all have safe chlorinated water supplies and all meet labor camp requirements.

The trend in migrant labor for the last several years has been a transition from off-shore labor to domestic laborers and their families as the latter tend to be much more dependable than the single male. Most camps in this area have been converted to one and two room apartments for families. New facilities are needed and are being planned.

These family camps are presenting new problems, including social, financial, and educational - schooling, health and general safety, since the mother may be working in the grove or field. In the camp we have less control over the family living conditions than before as we do not have as free access to the family apartment.

B. The Florida Labor Camp Law is based on Florida State Board of Health 170C-32. The Florida State Sanitary Code and the Orange County Building Code are used as the criteria for evaluating housing. Septic tank permits are issued by Orange County.

Some of the factors leading to the improvements in housing are:

1. Change from barracks to apartment units has resulted in remodeling.
2. The camp owners have been able to show increased revenue this past year and are more willing to spend money on camps.
3. Growers are in need of good help and are more willing to provide better quarters to keep good help in their employ.
4. All governmental agencies are more concerned and have raised the requirements to improve camp conditions to make them acceptable for interstate migrant workers. The following are factors which are creating problems for the camp owners in maintaining camp facilities.
    a. Family units are creating new problems which the off-shore worker did not present.
        1. Care of children;
        2. Vandalism in camp by children;
        3. Family problems;
        4. Abandoned automobiles;
        5. Safety factors;
        6. General sanitation and communicable disease problems.
    b. Reasons for unsatisfactory progress would be:
        1. Lack of profit for camp owners;
        2. Indifference of migrants regarding the property of others and destruction of owner's property.

C. All of the labor camps in Orange County have a potable water supply and water is chlorinated to safeguard the water supply. All public water supplies in the migrant areas are routinely checked and the health department checks any private supply upon request.

All of the labor camps have modern sanitary facilities and have adequate sewage disposal methods. These methods are either septic tank and drainfield disposal or package sewer plant disposal. The project sanitarian and all other sanitarians in the migrant area working for the Orange County Health Department check complaints, make inspections and offer suggestions on any sewage disposal problems in individual migrant homes.

Garbage and refuse disposal operations are very adequate. The primary disposal method in most camps is a landfill operation whereby the camp owner collects and buries his own garbage and refuse in a landfill. Several camps are served by commercial garbage and refuse companies servicing their particular area. Again, the greater problems of garbage and refuse disposal in the community, as a whole, is where the migrant does not have a garbage collection agency or will not satisfactorily, or properly, dispose of his own garbage and refuse. The migrant project sanitarian and others involved are constantly following-up complaints on garbage and refuse in yards creating health hazards.

Migrant labor camps which offer apartment type living furnish refrigerators for apartment units. Common kitchen areas in camps occupied by single men have refrigeration furnished in the common kitchen.

Comments on the adequacy of food handling practices, insect and rodent control, recreational facilities and general cleanliness in camps is as follows:

1. Food handling practices in camps having a central kitchen are very good. The project sanitarian periodically checks all kitchen facilities, food handling habits, and health cards of kitchen personnel. The equipment and buildings must meet the standards of the State Board of Health code for such establishments. In the camps with apartments, very little contact has been possible with the migrant worker but some attempt at education is being done through the use of pamphlets.

2. Insect and rodent control - all labor camps in the area have contracts with exterminating companies for periodic spraying for rodent and insect control. In addition, the County Arthropod Control will spray for mosquitoes in adjacent.areas when asked by camp owners or the sanitarian in the area. During the mosquito season Orange County maintains a larvicide program in all areas of the county, including the migrant areas.

3. Recreational facilities are normally inadequate due to the reluctance of the owners to absorb the expense of vandalism of the facilities by the migrants. Some camps do offer a building that may be used for various recreational functions and some other facilities for children in the camp.

4. General cleanliness in camps - most camps in the Orange County area maintain a high level of camp cleanliness. This has been attained through the combined cooperation of all people concerned, the growers, camp owners, the project sanitarian, all of whom have stressed cleanliness to the workers in the camps in an attempt to educate migrants to the proper disposal of garbage and the importance of general cleanliness.

III. General description of work environment - water supply, hand-washing facilities; food handling and toilet facilities:

A. Water supply for the field worker in most situations is unavailable. Drinking water is supplied in large containers carried on trucks and attempts are made to have single service drinking cups instead of the common cups being used. The water supply in the processing or storage areas is normally available.

B. Hand-washing facilities on normal grove or field operations are not available but are not normally available in processing or storage facilities.

C. In the matter of food handling, some of the larger work crews are given a lunch which is prepared in the central kitchen in the labor camp. Migrants living in the camp apartments fix their own bag lunch, which is carried to the field with them. The food prepared in the central kitchen is prepared under good sanitary conditions but the food from the homes may not be as sanitary since we cannot control the individual's habits.

D. Toilet facilities in the field are never adequate at best and most cases reveal that the toilet facilities are not convenient and not up to standard. In some cases, sanitary privies are being moved from one field location to another as the migrants are working in the various fields. Progress is being made to maintain facilities at a higher level with periodic inspections of privies by a foreman, owner and sanitarians.

IV. Efforts in health education are on a small scale but, as time is available, the project sanitarian and other sanitarians working in the project area distribute literature and pass-outs to migrants in the camps and to camp managers. An effort is made at all times not only to inspect facilities in the camps but to have personal contact with migrants and camp managers in educating the migrants in various phases of sanitation. The health education materials have been supplied by the Orange County Health Department health educator, at his suggestion, and with his cooperation in the project. Plans are being formulated to conduct health education sessions along with the clinics. This is an ideal time to give information to migrants concerning sanitary habits and general health education since time is available while they are waiting for their appointments.

V. General appraisal of sanitation program:

A. Extent of success in meeting specific objectives: We have met with great success in the past year in improving the environmental health aspects for the migrants' existence.

B. These aspects were improved in the camp through stricter control and endeavors in the enforcement of camp regulations.

Improvement in relations between migrants and the community: We were successful in creating an atmosphere of understanding and willingness to improve conditions by cooperation with local news media and through the presentation of several very effective documentary films on local television.

We were able to inform the general public and governmental and civic groups of the project's aims and the migrant problems in our particular area.

Objectives in furnishing the migrant with a minimum standard of water, sewage, housing and general sanitation were met. There were some disappointments in some areas:

1. Lack of cooperation on the part of some migrant laborers to take care of facilities provided them;

2. Little progress was made in solving problems created by unattended children under school age in the camps.

3. Periodic inspections were made during the year and defects in the camps were discussed with camp owners or managers. In all cases

the camp owners have been very good in complying with all requests. The camps in Orange County are operated by owners for a profit rather than by the grower in most cases. Facilities have been well filled this year and camp owners have been willing to spend money on the camps as they have been returning a profit. One camp that has been a problem in the past has improved a great deal due to effective supervision and new personnel.

4. Education of migrants and health habits have been stressed by camp supervisors. This has helped to keep camps in better condition.

VI. The immediate future seems to point to a need in Orange County for additional labor camps. Last year one new camp was started in the county. Inquiries have been received pointing to the possibility of two or three new labor camps for the coming year. These camps will surely all be the type catering to family groups. The basic problems initially will be to obtain zoning permission for labor camps in some proposed areas and financing for the construction of the camps. As camps are constructed, the problems that have presented themselves in our existing camps will also arise in the new camps.

New camps are being proposed in populated areas for transportation and shopping center convenience of the camp dwellers. The existing home owners in the community, in many cases, do not want labor camps adjacent to their homes or community. This is creating some ill will and reluctance on the part of zoning boards to license labor camps in suburban areas. Even though we should have an increase in labor camps, the majority of migrant families will continue to come into the local area and find their own housing. Our problems will continue to remain about the same in the migrant labor camp and our past objectives can surely be achieved with cooperation from camp owners, growers, and all concerned health department personnel.

Our major efforts in the coming year must be to find the best methods of educating and giving all health services to the migrant families that are living in our community in addition to the migrants living in the camps. These objectives can only be met by the complete cooperation of all concerned disciplines in the health department. This includes doctors, nurses, health educators, sanitarians, clerical personnel, etc. In addition, these people must work with all other interested governmental and area civic groups. Much progress was made this past year in achieving understanding and cooperation of all these various bodies. It is our basic objective for the coming year to broaden these understandings and devise a workable relationship that can be applied to the migrant labor community.

PALM BEACH COUNTY HEALTH DEPARTMENT

C. L. Brumback, M. D., Director

Area of County:	2,700 square miles
Resident Population:	228,106
Migrant Health Project Staff:	1 Public Health Nurse Supervisor 3 Public Health Nurses 5 Clerk-Typists 1 Motor Vehicle Operator 2 Clinic Aides 1 Sanitarian Supervisor 4 Senior Sanitarians 1 Sanitation Aide 1 Health Educator 1 Health Field Worker

HEW-PHS
Wash., D.C.

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT

PALM BEACH COUNTY

For May 1, 1967 through April 30, 1968
Date submitted July 1, 1968

PART I GENERAL PROJECT INFORMATION

1. Project Title
COMPREHENSIVE HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS IN PALM BEACH COUNTY

2. Grant Number (use number shown on approved application)
MG-11 E (68)

3. Name and Address of Applicant Organization
Palm Beach County Health Department
826 Evernia Street - P. O. Box 29
West Palm Beach, Florida 33402

4. Project Director
C. L. Brumback, M. D., M. P. H.

5. Population Data - Number of Migrants (workers and dependents) for Palm Beach County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	20,977	10,698	10,279
Under 1 year	639	300	339
1 - 4 years	3,367	1,476	1,891
5 - 14 years	4,438	2,269	2,169
15 - 44 years	8,822	4,525	4,297
45 - 64 years	2,935	1,722	1,213
65 and older	776	406	370
2. In-migrants			
Total	10,000	6,300	3,700
Under 1 year	203	107	96
1 - 4 years	1,096	567	529
5 - 14 years	2,366	1,260	1,106
15 - 44 years	5,408	3,780	1,628
45 - 64 years	815	504	311
65 and older	112	82	30
* Grand total	30,977	16,998	13,979

b. Number of migrants by month:

Month	Total	Month	Total
Jan	38,342	Jul	11,381
Feb	36,688	Aug	11,670
Mar	34,692	Sep	14,748
Apr	27,122	Oct	22,105
May	19,640	Nov	31,450
Jun	12,435	Dec	35,717

c. Average stay of migrants in county:
Out-migrants: 39 weeks
from Sept. (mo.) through May (mo.)
In-migrants: 26 weeks
from Nov. (mo.) through April (mo.)

d. Source of information and/or basis of estimates:
Census counts in camps and other housing.

6. Housing accommodations for Palm Beach County:

a. Camps

Maximum Capacity	Number	Occupancy(peak)
Less than 10 persons	**	
10 - 25 persons	9	129
26 - 50 persons	38	949
51 - 100 persons	31	1,437
More than 100 persons	54	17,411
Total	132	19,926

b. Other housing accommodations

Type	Number	Occupancy(peak)
Farms	86	754
Other locations***	1,608	17,662

c. Append map showing location of camps, roads, clinics, and other places important to project.

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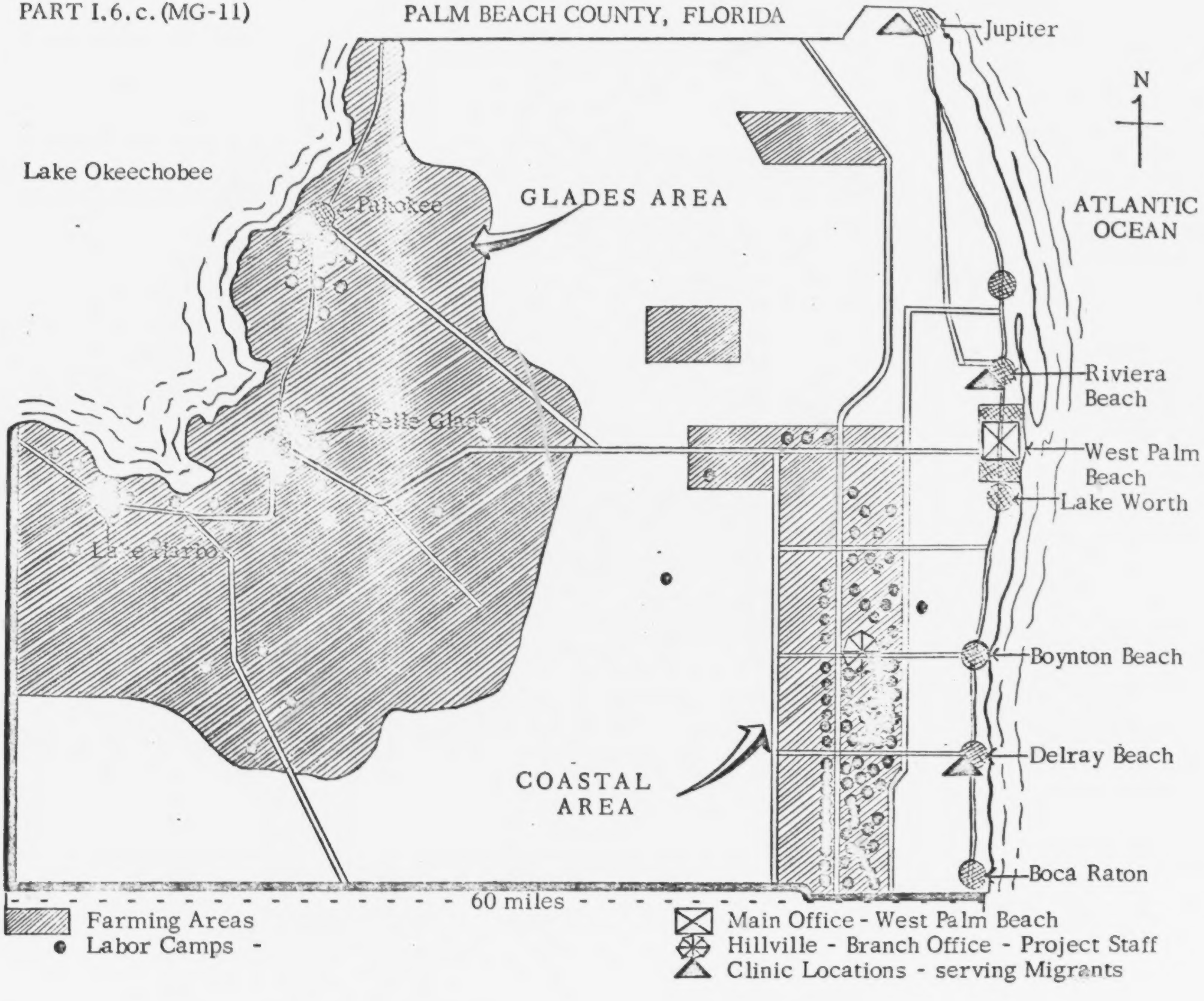
* Does not include 7,627 male offshore workers.

** Florida law defines labor camps as 15 or more persons. Camps of less than 15 persons are included as other housing.

*** Includes 415 rooming houses with a peak occupancy of 8,113

PALM BEACH COUNTY, FLORIDA


Lake Okeechobee
Pahokee
Belle Glade
Lake Harbor
GLADES AREA
COASTAL AREA
Jupiter
N
ATLANTIC OCEAN
Riviera Beach
West Palm Beach
Lake Worth
Boynton Beach
Delray Beach
Boca Raton
60 miles
▨ Farming Areas
● Labor Camps -
☒ Main Office - West Palm Beach
Hillville - Branch Office - Project Staff
△ Clinic Locations - serving Migrants

PALM BEACH COUNTY

Project No. MG-11E(68)
Date submitted July 1, 1968

PART II MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of visits
	Total	Male	Female	
Total				2,836
Under 1 year	155	71	84	645
1 - 4 years	137	65	72	754
5 - 14 years	164	80	84	562
15 - 44 years	542	82	460	1,645
45 - 64 years				181
65 and older	5	NA	NA	49

2. Patients hospitalized:

Age	Number of patients			Hospital Days
	Total	Male	Female	
Total	227	87	140	1,702 3/4
Under 1 year	26	13	13	240
1 - 4 years	14	6	8	98
5 - 14 years	7	3	4	58
15 - 44 years	159	48	111	936 3/4
45 - 64 years	21	17	4	370
65 and older	0	0	0	0

3. Patients receiving dental service:

Item	Total	Under 15	15 and older
a. Number of migrants examined: total	436	374	62
Number of decayed, missing, filled teeth-	1,889	1,565	324
Average DMF per person	4.3	4.2	5.2
b. Individuals requiring services: total	436	374	62
Cases completed	145	129	16
Cases partially completed	291	245	46
Cases not started	0	0	0
c. Services provided: total	1,484	1,357	127
Preventive	382	317	65
Corrective	729	727	2
Extraction	205	161	44
Other	189	173	16
d. Patient visits: total	733	607	126

4. Immunizations provided:

Type	Incomplete series	Completed immunizations, by age					Boosters, revaccinations
		Total	Under 1 year	1-4	5-14	15 and older	
All types	890	2677	346	872	785		674
Smallpox		229	4	47	154		24
Diphtheria	267	726	88	214	159		265
Pertussis	161	473	88	214	84		87
Tetanus	275	656	88	214	164		190
Polio	187	479	72	122	177		108
Typhoid	--	--	--	--	--		--
Measles	--	114	6	61	47		--
Other (specify)	--						

Part II

5. Medical conditions found by physicians among outpatients, by age of patient

PALM BEACH COUNTY

Project No. MG-11E (68)
Date submitted July 1, 1968

Rangeline Family Service Clinics: June 1, 1967 to April 30, 1968

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
I	Infective and parasitic dis.	303	27	116	96	48	16	
	Tuberculosis	7	2			4	1	
	Venereal disease	36				30	6	
	Measles	2		2				
	Infestation with worms	204	10	104	83	7		
	Dermatophytosis & other infections of skin	54	15	10	13	7	9	
	Other							
II	Neoplasms	11			1	5	5	
	Malignant	6				3	3	
	Benign & unspecified	5			1	2	2	
III	Allergic, endocrine, metabolic, and nutritional dis.	96	10		10	50	25	1
	Diabetes	42			6	18	17	1
	Malnutrition	9	8		1			
	Other Obesity	45	2		3	32	8	
IV	Dis. of blood and blood-forming organs	40	17	13	4	5	1	
	Anemias	39	17	13	3	5	1	
	Other Hepatitis	1			1			
V	Mental, psychoneurotic and personality disorders	26	2	4	7	10	3	
VI	Dis. of nervous system and sense organs	167	36	83	38	9	1	
	Cerebro-vascular disease (stroke)							
	Eye diseases	60	14	28	13	4	1	
	Dis. ear and mastoid process	97	22	52	21	2		
	Other dis. of nervous system Epilepsy	10		3	4	3		
VII	Dis. of circulatory system	92			6	46	32	8
	Rheumatic fever	6			4	2		
	Diseases of the heart	8			2	2	2	2
	Hypertension & other dis circulatory system	78				42	30	6
VIII	Dis. of respiratory system	618	183	263	112	47	13	
	Upper respiratory	296	95	128	60	8	5	
	Influenza and pneumonia	88	25	48	14	1		
	Bronchitis	212	61	78	32	33	8	
	Other Asthma	22	2	9	6	5		

Part II

5. Medical conditions found by physicians among outpatients, by age of patient (Cont)

PALM BEACH COUNTY

Project No. MG-11E(68)
Date submitted July 1, 1968

Rangeline Family Service Clinics: June 1, 1967 to April 30, 1968

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
IX	Digestive system diseases	105	42	45	13	3	1	
	Teeth and supporting structures	14	2	8	3			1
	Gastroenteritis, colitis	81	30	37	10	3	1	
	Other Diarrhea	10	10					
X	Dis. of genito-urinary system	40	6	2	4	24	4	
	Urinary system diseases	31	2	2	4	22	1	
	Genital system diseases	9	4			2	3	
XI	Deliveries and complications of pregnancy							
	Complications of pregnancy							
	Deliveries							
	Complications of puerperium							
XII	Skin diseases	110	14	49	41	5	1	
	Impetigo	97	10	44	39	4		
	Other	13	4	5	2	1	1	
XIII	Dis. of bones & organs of movement	8			4	4		
XIV	Congenital malformations	16	6	5	5			
XV	Dis. of early infancy	4	4					
XVI	Symptoms, ill-defined cond.	53	3	4	8	30	8	
XVII	Accidents, poisonings, violence	14	1	4	7	2		
	TOTAL OF CATEGORIES I-XVII	1,677	349	584	349	278	107	10
SUPP	Special conditions, examinations, without sickness: Total							
	Prenatal, postnatal care					191*		
	Physical examination	15			12	3		
	Immunizations	See	Part II.	4.				
	Surgical or medical after-care, follow-up	16	1	3	4	7	1	
	Fitting prosthetic devices							
	Other							
	Family Planning					128**		

* Maternity visits - 732
** Family Planning - 708

Part II DOMESTIC AGRICULTURAL WORKERS-"Glades" Triage Clinics

PALM BEACH COUNTY 5. Medical conditions found by physicians among outpatients, by age of patient

Project No. MG-11 E (68)
Date submitted July 1, 1968

Total no. patients cleared by nurses (sent to doctors, clinics, etc.). . 526 : Total no. visits. . . 1, 124.

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
I	Infective and parasitic dis.	23	1	1	4	6	8	3
	Tuberculosis							
	Venereal disease							
	Measles							
	Infestation with worms							
	Dermatophytosis & other infections of skin							
	Other							
II	Neoplasms	13				3	9	1
	Malignant							
	Benign & unspecified							
III	Allergic, endocrine, metabolic, and nutritional dis.	13				5	5	3
	Diabetes							
	Malnutrition							
	Other							
IV	Dis. of blood and blood-forming organs	14			3	4	6	1
	Anemias							
	Other							
V	Mental, psychoneurotic and personality disorders	5				3	2	
VI	Dis. of nervous system and sense organs	46	1	6	14	11	13	1
	Cerebro-vascular disease (stroke)							
	Eye diseases							
	Dis. ear and mastoid process							
	Other dis. of nervous system							
VII	Dis. of circulatory system	72		2	7	20	32	11
	Rheumatic fever							
	Diseases of the heart							
	Hypertension & other dis. circulatory system							
VIII	Dis. of respiratory system	95	1	21	14	25	34	
	Upper respiratory							
	Influenza and pneumonia							
	Bronchitis							
	Other							

Part II DOMESTIC AGRICULTURAL WORKERS
"Glades" Triage Clinics (continued)

5. Medical conditions found by physicians among outpatients, by age of patient (Cont)

PALM BEACH COUNTY

Project No. MG-11 E (68)
Date submitted July 1, 1968

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
IX	Digestive system diseases	54	7	15	7	16	7	2
	Teeth and supporting structures							
	Gastroenteritis, colitis							
	Other							
X	Dis. of genito-urinary system	22			10	10	1	1
	Urinary system diseases							
	Genital system diseases							
XI	Deliveries and complications of pregnancy	17				17		
	Complications of pregnancy							
	Deliveries							
	Complications of puerperium							
XII	Skin diseases	44	2	12	15	8	3	4
	Impetigo							
	Other							
XIII	Dis. of bones & organs of movement	17		2	4	4	6	1
XIV	Congenital malformations							
XV	Dis. of early infancy							
XVI	Symptoms, ill-defined cond.	13			5	4	4	
XVII	Accidents, poisonings, violence	34		4	13	11	4	2
	TOTAL OF CATEGORIES I-XVII	482	12	63	96	147	134	30
SUPP	Special conditions, examinations, without sickness: Total							
	Prenatal, postnatal care							
	Physical examination							
	Immunizations							
	Surgical or medical after-care, follow-up							
	Fitting prosthetic devices							
	Other: Family Planning	25			1	24		
	Well Baby	20	20					

Project No. MG-11E(68)

PALM BEACH COUNTY

Date Submitted July 1, 1968

PART III NURSING AND SANITATION SERVICES

1A. Nursing services (field nursing)	Number	Services provided:	Numbe
a. Visits to households		f. Health supervision, counselling, teaching, demonstrating care	1,418
b. Total households served	580		
c. Visits to schools, total	10	g. "Sick call" (nursing clinics)	184
d. Migrants presenting health record on request (PHS 3652) in field	1,692 (in clinic)	h. Referrals for medical or dental care: total - see "referrals"	
		Within area: total	
		Number completed	
e. Migrants given health record	986 (in clinic)	Out of area: total	NA
		Number completed	NA
B. Total individuals served	1,418	i. Other (specify) Not home-sick call - 1 hr. evy. day-Mon. & Fri.	297

2. Sanitation services

Table A. Survey of housing accommodations of migrants

Housing accommodations	Total number	Number with Permits	Housing units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	132	104	2,139	879	5,358	1,562	1,141	13,224
Urban or other locations	1,694	1,321	1,518	1,188	5,940	** 5,382	5,382	13,456

Table B. Inspection of living and working environment of migrants

Item	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	743	2,578	256	129
b. Sewage	743	2,578	1,419	644
c. Garbage and refuse	743	2,578	594	258
d. Housing	743	2,578	1,114	436
e. Safety	743	2,578	216	89
f. Food handling	743	2,578	2,347	488
g. Insects and rodents	743	2,578	252	141
h. Recreational facilities	743	2,578	254	126
Working environment				
a. Water	124	182	108	11
b. Toilet facilities	124	182	78	9
c. Other	124	182	148	34

* Locations - camps or other locations where migrants work or are housed

** Reflects the total number of sleeping rooms in the 415 rooming houses which are licensed by the Florida Hotel & Restaurant Commission.

MIGRANT HEALTH PROJECT GRANT, MG-11E (68)

ANNUAL PROGRESS REPORT

COMPREHENSIVE HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS IN PALM BEACH COUNTY, FLORIDA

INTRODUCTION

This special project was renewed, effective January 1, 1968, by the U. S. Public Health Service, Migrant Health Branch. It combines the services previously provided by grants from the Children's Bureau, Welfare Administration, Department of Health, Education, and Welfare, for services to mothers and children, and the U. S. Public Health Service, Department of Health, Education, and Welfare, for programs in environmental health and health education.

The Annual Progress Report includes information on services provided by the project as prescribed by the Migrant Health Branch.

The Migrant Health Project in Palm Beach County functions in close cooperation with the Maternity and Infant Care Project funded by the Children's Bureau, and with a Tuberculosis Control Project funded by the U. S. Public Health Service.

PART III - Nursing Supplement.

In addition to the information in Part II. 5, Medical Conditions Found Among Outpatients for the "Rangeline" Area, the following information on nursing service for Part III - Nursing:

f. Health supervision counselling, teaching and demonstrating care is provided for all patients visited, according to their needs. Special demonstrations and counselling are provided during clinic session.

g. Sick call - two hours each day is provided at health center.

h. No count has been kept on patients referred to Family Service Clinics (see report).

Special follow-up is reported in separate section.

Dental care for adults is provided only in extreme emergencies.

The two Migrant Kindergarten programs held this year provided dental care for approximately 200 children on the "Rangeline."

There were 33 referrals made to dentists from the migrant school and 28 of these were completed.

The table on page 6, Part II. 5, entitled Medical Conditions Found Among Outpatients, combines the results of the triage clinic established in Pahokee and Belle Glade in the Western "Glades" Area after the Pahokee night clinic was cancelled.

The figures are for conditions by ICD class group rather than by separate condition. This is due to the difficulty in identifying the true migrant patient. All the patients seen in the clinic, however, are classified as domestic agricultural workers and are eligible for county welfare services if they meet the residence requirement.

There were 20 night clinics held in Pahokee from July to December, 1967, with a total of 268 patients seen as outpatients.

See Part IV, Narrative, for details of this clinic operation.

COMPREHENSIVE HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS IN PALM BEACH COUNTY

PART IV: NARRATIVE FOR ANNUAL PROGRESS REPORT

Project No. MG-11E (68)
Date Submitted: July 1, 1968

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1. General Information

A. Period covered by narrative report:

May 1, 1967 - April 30, 1968

B. Objectives as listed in last approved application:

1. To continue to provide family health service clinics in the eastern agricultural area of Palm Beach, County, utilizing the multi-disciplinary, team approach to outpatient medical care with emphasis on preventive medicine.

2. To begin a migrant family health service clinic in the Pahokee area of Palm Beach County for general outpatient medical care with an emphasis on preventive medicine.

3. To develop and operate a hospitalization plan for domestic agricultural migrants whereby the area hospitals provide necessary inpatient medical care on a cost reimbursement, reasonable fee basis.

4. To provide total family oriented public health nursing services to the migrant population in Palm Beach County in cooperation with existing health department programs and Maternity and Infant Care Project. Public health nursing to include:

   a. Public health nurse field visits for health supervision and case-finding on a regularly scheduled basis to:

      (1) migrant camp area,
      (2) non-camp, migrant housing within municipalities.

   b. Home health care under medical direction for acutely or chronically ill on referral by area hospitals, physicians, and clinics.

   c. Intensive public health nursing services to schools with a high migrant student enrollment.

   d. Planning and implementation of group health educational activities adapted to the migrants.

   e. Regular public health nurse visits to all area hospitals with migrant patients for coordination of services and continuity of care.

5. To develop and operate a dental care program for domestic agricultural migrants of all ages.

6. To conduce a migrant housing program covering all types of housing used by migrants and using all available resources to achieve maximum standards of environmental sanitation. The sanitation services to include:

   a. Consultation and guidance to growers, health department staff members, personnel of other agencies, and others concerned with migrant sanitation.

   b. Inspection, consultation, and evaluation of findings on periodic visits to migrant labor camps, rooming houses, and other migrant housing, making recommendations for improvements as indicated.

   c. Consultation to growers and others in regard to migrant housing design and construction.

   d. Advisory and instructional services to migrant workers and families in all types of housing to improve their standards of environmental health.

7. To continue to define the health education needs of migrants and, based on these needs, to provide a program of health education for the improvement of personal and environmental health of migrants.

8. To solicit the cooperation of and to provide assistance to all official groups providing services to migrants.

9. To expand and intensify the orientation and in-service training for project and non-project personnel involved in migrant services.

10. To inform the general public of the health needs and services for domestic agricultural migrants.

C. Changes in objectives from preceding project period, and reasons:

   1. There was only one objective that had to be changed during the project year. Objective #2, "To b egin a migrant family health service clinic in the Pahokee area of Palm Beach County for general outpatient medical care with an emphasis on preventive medicine," was accomplished, and the clinic functioned for several months but was discontinued due to the loss of clinic physicians and public health nurse.

D. Significant changes in migrant situation from previous year:

   1. The migrants themselves.

      a. Age and sex composition.

      The age and sex composition of the migrants who come to Palm Beach County each year is rather difficult to obtain with any degree of accuracy due to the large number that come in from all parts of the Atlantic seaboard (approximately 30,000) and also to their in-migration within the county once the harvesting begins. In order to determine the age and sex composition of the migrants, a random sampling census was completed with a projection of at least ten per cent of the migrant population, covering all types of housing accommodations, not only in the coastal area, but also in the "Glades."

As a result of this special effort, a total of 3,180 migrants were counted, reflecting 10.4 per cent of the population. Based on the results of this random sampling, the age and sex composition of in-migrants and out-migrants in Palm Beach County is projected as shown in 5.a. of Part I.

The table on page no. 13 shows the age and sex composition of the 3,180 migrants counted in the random sampling, with the percentages of each age and sex group. These percentages were used to compute the number of migrants by age and sex, as shown in Part I. 5.a. The sample size is considered too small to provide accurate data, and also the sampling was done in late March and April, which was well past the peak month of January. An attempt will be made next season to conduct a random sampling of at least 25 per cent during the peak months.

b. Cultural and ethnic background of the migrants in the two agricultural areas of Palm Beach County are:

"Rangeline," Eastern Area Ethnic Composition:

	Number	Per Cent
Southern Negro	7,627	50.3
Mexican American	3,350	22.1
Puerto Rican	3,525	23.2
Other (Anglo, Indian, Cuban)	670	4.4
Total	15,172	100.0

c. The majority of the migrants (66 per cent) consider Palm Beach County as home as they spend seven to eight months of the year in this county. The Mexican-Americans consider Texas their home regardless where they come from. The Puerto Ricans, who make up approximately 25 per cent of the migrant labor force, come to Palm Beach County by way of New York or New Jersey and plan to return to their native land even though they migrant from South Florida to New Jersey and New York.

d. The Negro migrant originally came from all the southeastern states, with Georgia and Mississippi having the greatest representation, although it is very difficult to give exact figures of the number that came from each state. Most migrants continue to plan to follow the "stream" along the Atlantic seaboard to New Jersey, New York, and other northern states, with some crews branching off to Michigan and other midwestern states.

e. The beginning and ending dates of the season have remained as in the past year, with the season starting in November and ending in May. Weather was a factor on the positive side, with Palm Beach County enjoying one of the mildest winters in years. This excellent grow-weather resulted in an abundant harvest of all types of crops. There was ample work for all the migrants. Crop loss due to excessive rain or freezing weather was insignificant and did not have any effect on the seasonal crops.

Market conditions were generally favorable, with the price of all truck crops remaining at a high level. This was due to crop losses in Texas and Mexico as a result of hurricane damages, and to the high quality of the vegetables.

b. There was no basic change in the type of crop from previous years. In the eastern or coastal area of Palm Beach County and north of West Palm Beach, there was an increase in tomato acreage. Other land is being cleared and drainage systems installed for the growing of citrus, which will increase the need of pickers unless mechanization develops to a high degree to lessen this need. It is too early to predict the course this citrus crop will take as it will be several years before the need for workers will be realized. By that time, mechanization of citrus may be developed to a higher degree.

c. The increased tomato acreage and the fact that mechanization of fresh tomatoes has not been fully developed, means the need for agricultural workers will continue to remain at relatively the same level. Machine harvesting of beans and sugar cane has not increased dramatically over last year. One grower uses hand labor for the first picking of beans to obtain premium prices, and uses machines for the remainder. There seems to be some question of the quality of beans harvested by machine versus hand-picking. It is reported that brokers received complaints from wholesalers of excessive damage to beans harvested by machine. It is difficult to evaluate the reliability of this report, and the effect this will have on the fresh vegetable market. It seems certain that the need for migrant agricultural workers will continue at the same level as last season. As mechanization becomes more sophisticated so that crops will not be damaged or bruised during harvesting, the type of labor required may shift from pickers to mechanics, equipment maintenance men, drivers, and others.

An interesting aspect of the utilization of the mechanical harvester is the case of one farmer harvesting 800 acres of corn exclusively by machine. On the other hand, excellent weather, an abundance of labor, and other factors precluded the increased use of mechanization. The indications are that machines will be available in the event labor becomes critically short.

3. Need for health services:

The need for health services to agricultural migrants continues to be one of high priority as evidenced by the increase in the number of patient visits to the clinics as outpatients, and the results of the inpatient hospitalization phase of the program experienced this reporting year.

There was a total of 1,995 patients seen in clinics in the "Rangeline" area this reporting year, representing a 9.4% increase over the last reporting year. The total number of clinic visits was 3,936, representing a 10.2 per cent increase.

More funds for inpatient hospitalization are needed in Palm Beach County to provide assistance to those migrants requiring elective surgery that will enable the migrant to become employable, as well as to reduce the financial loss the hospitals incur in the admission of migrants.

II. General description of project operations during year.

A. Medical and dental services.

1. Clinic sites and schedules.

a. Eastern, "Rangeline" Area.

The number of clinic sites was reduced to one with the Rural Migrant Clinic located at Hillville, rural Boynton Beach, just east of State Road 7, being the only site used this period. During the migrant season, from October through May, there is one night clinic and one afternoon clinic each week. From May thru September there is one afternoon clinic, for a total of 67 clinic sessions for the year. The mobile clinic is used as examining rooms by the physicians as it is located adjacent to the Hillville Station, which is the headquarters for project personnel. The mobile clinic continues to provide facilities for the two clinic physicians, one a pediatrician and the other an internist, both of whom are bilingual.

b. Western, "Glades" Area.

The health department clinics in Belle Glade and Pahokee function daily as part-time migrant medical clinics in conjunction with doctors' offices on an appointment basis.

TYPES OF SERVICES OFFERED

Eastern, "Rangeline" Area - Mobile Clinic:

Routine diagnostic procedures: Serological tests for syphilis, skin testing for tuberculosis, PKU (Guthrie test), urine test for protein and sugar, hematocrit and hemoglobin, stool cultures for enteric pathogens, stool examination for ova and parasites, and sputum examination for acid-fast bacilli.

Immunizations: Active immunization for diphtheria, pertussis and tetanus, polio, smallpox, and measles.

PALM BEACH COUNTY HEALTH DEPARTMENT - MG-11
RANDOM SAMPLING RESULTS OF MIGRANT POPULATION
As of April, 1968

MALE IN-MIGRANT

Age Group	0 - 1	1 - 4	5 - 14	15 - 44	45 - 64	65+
% Total Count.	1.7%	9.0%	20.0%	60.9%	8.0%	1.3%
No. Counted	14	79	176	522	69	11
Projected Est.*	107	567	1,260	3,780	504	82
				Total number counted		871

MALE OUT-MIGRANT

Age Group	0 - 1	1 - 4	5 - 14	15 - 44	45 - 64	65+
% Total Count.	2.8%	13.8%	21.2%	42.3%	16.1%	3.8%
No. Counted	26	127	196	391	149	35
Projected Est.**	300	1,476	2,269	4,525	1,722	406
				Total number counted		924

FEMALE IN-MIGRANT

Age Group	0 - 1	1 - 4	5 - 14	15 - 44	45 - 64	65+
% Total Count.	2.6%	14.3%	29.9%	44.0%	8.4%	.8%
No. Counted	13	72	150	221	42	4
Projected Est.*	96	529	1,106	1,628	311	30
				Total number counted		502

FEMALE OUT-MIGRANT

Age Group	0 - 1	1 - 4	5 - 14	15 - 44	45 - 64	65+
% Total Count.	3.3%	18.4%	21.1%	41.8%	11.8%	2.6%
No. Counted	29	163	186	369	104	32
Projected Est.**	339	1,891	2,169	4,297	1,213	370
				Total number counted		883

GRAND TOTAL COUNTED - Random Sampling 3,180

TOTAL IN-MIGRANTS COUNTED: 1,373
Representing 43.2% of total migrants counted;
which represents 13.7% of 10,000 total in-migrants.*

TOTAL OUT-MIGRANTS COUNTED: 1,807
Representing 56.8% of total migrants counted;
which represents 8.6% of 20,977 total out-migrants.**

Social Service: Social data necessary for hospitalization arrangements, completion of referrals to community agencies, and assistance as indicated. (See picture - Plate B.)

Family Planning: Individual and group education and counseling, history and physical examination by clinic physician, and dispensing of the family planning medications and insertion of devices. (See picture - Plate C.)

Nutritional Consultation: Provided for individual patients by nutritionist and the public health nurses. (See Plate C.)

Outpatient Medical Care: Diagnosis and treatment of infants, children and adults, including routine prenatal and postpartum care, and dispensing of basic medications.

Western, "Glades" Area:

Both clinics provided general outpatient services, primarily on a referral basis, from the public health nurse and the County Welfare Department. Patients acutely ill are seen in a private physician's office. The clinics provide similar services as the mobile clinic, including immunizations, family planning, and outpatient medical care for adults and children.

The Pahokee and Belle Glade Health Department clinics serve primarily as triaging clinics for the Glades migrants. Those in need of maternity or family planning or pediatric care will be referred to establish MIC clinics in both Belle Glade and Pahokee. Migrants with acute or chronic illnesses are given appointments at local physicians' offices for care. These will be paid for on a usual and customary fee basis. Traditional public health services, such as T.B., V.D., and immunization clinics, will continue to be centered in the established local health departments in the Glades.

While this may seem fragmented, it works very well, and indeed is good comprehensive health care. Where a deficiency exists in sophistication of care, it is made up by the willingness of small town physicians and health department workers to provide family style services, and in many cases, the patients are known on a first name basis.

This cooperation of the public and private health services has enabled the migrant project to serve patients on a seven day a week basis rather than on a once or twice a week clinic schedule.

Dental services are provided under E.S.E.A., Title I, in cooperation with the Palm Beach County Board of Public Instruction.

2. Other medical and dental services.

The branch offices of the health department in Pahokee and Belle Glade, in association with the special MIC clinics, provide comprehensive medical service to migrants. These include a full-time health officer for V.D. and T.B. clinics, a pediatrician and obstetrician for pediatric and maternity clinics, as well as a general practitioner for family planning clinics in Belle Glade.

General care for acute and chronic illnesses is provided by private physicians in the area. The public health nurses provide comprehensive nursing care to all patients, including migrants.

No effort is being made to establish a separate medical facility exclusively for migrants in this area. The domestic agricultural migrants in Pahokee and Belle Glade consider this area their home. They maintain permanent addresses here, and often the family remains in this area while the father or some other member of the family migrates north only during the summer months. These people feel and act like permanent residents of the "Glades," in contradistinction to the agricultural migrants in the Eastern, or "Rangeline" area. They have long ago established rapport with local physicians, and seek their services when they become ill. Many prefer to pay for their own medical care while they are working in the winter months, and we do not want to change this relationship.

3. Health education as part of service. Refer to health education section for further information.

4. Referrals for additional care, and results.

Patients seen in the migrant health clinics are referred to various specialists for conditions requiring further diagnosis and treatment. The number referred is small - less than five per cent of the total number of patients seen. This is related to two factors - one, the high caliber of care given in the clinics, and secondly, patients with severe, acute illnesses or accidents usually present themselves to emergency rooms for definitive care. They are often hospitalized and given the necessary care.

Referrals for dental care are shown in Part II. Item No. 3. This includes dental care provided by the two dental clinics in the health department as well as the mobile dental clinic.

In the migrant project budget, no provision for in-hospital physician payment has been made, and we find it difficult to admit patients for anything other than emergency care. Provision for elective surgery and medical care is needed, with payment to the physician. An example would be the elective repair of an inguinal hernia. (See table on referrals below):

MEDICAL AND DENTAL SERVICES:

Referrals for additional care this season have improved.

Florida Council for the Blind	25	20 completed
Florida Crippled Children's Commission	18	10 completed

Tumor Clinic	15	8 completed
Vocational Rehabilitation	23	10 completed
Surgeons	4	4 completed
Welfare for transportation to other areas	2	2 completed
Welfare for others	20	15 completed
Hospitalization - other than maternity	28	28 completed
Psychiatric Clinic	4	4 completed

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5. Personnel involved.

a. Eastern "Rangeline" Area, Hillville Clinic, medical, nursing, and others funded by project.

Physicians:	2/per clinic, 1 pediatrician, 1 internist.
Public Health Nurses:	3/per clinic, 1 assisting the physician, 1 administering immunizations, STS, PPD, etc., and 1 counseling with patients on family planning and making referrals.
Health Field Worker:	1 certifying migrants for in-patient hospitalization.
Clerks:	2 registering patients; preparing patients' records.
Clinic-Aide/Liaison:	2 assisting physicians, PHN, and serving interpreters.
Equipment Operator:	1 for transportation of patients to clinics, hospital, etc. Serves as interpreter, liaison worker and Sanitation Aide.

In addition to the above personnel, the two health department staff dentists provide dental services on referral by public health nurses. Non-project personnel presently funded by the Children's Bureau MIC Project:

Medical Social Worker:	1 arranging for hospitalization or maternity patients, and other social service.
Nutritionist:	1 on patient consultation.

b. Western, "Glades" Area.

A triage "sick call" clinic in Pahokee and Belle Glade is staffed by one public health nurse, one clinic aide, and one clerk. The other public health nurses provide generalized public health nursing service to the domestic agricultural workers. (See II.A.2. for detailed information.)

6. Changes from previous year.

There were two major changes in the provision of medical and dental services. First, a new method of triaging patients through the Pahokee and Belle Glade clinics was started. The public health nurse sorted out those patients in need of medical care and made appointments with a local physician for appropriate care. The nurse also made appointments to special clinics for well-baby checks, family planning visits, prenatal care, as well as referrals for the T.B. and V.D. clinics. Routine immunizations, blood tests and stool examinations continued to be performed in the health department by the public health nurse.

The opening of the migrant dental clinic in Belle Glade fulfilled a long-time need for dental services. The clinic is fully staffed, and operating on a five-day-a-week basis. Emphasis is on prophylactic and remedial dental services for the pre-school and school-age children. Emergency and some remedial treatment is given adult migrants as time permits. The emphasis and patient load will continue to cater to the needs of the young migrant, with expansion of services in the future, depending on the enlargement of the dental staff.

7. Future changes in medical and dental services are as follows:

   a. The movement of the dental trailer to the Eastern "Rangeline" area for four months to attend to the dental problems in that area.

   b. An increase in dental supplies to the dental trailer to carry on a more comprehensive and remedial dental program for the young.

   c. A continuing need, previously requested, is for inpatient physicians' services. There is a general reluctance on the part of private physicians to give inpatient care when there is no provision for payment of these services.

   d. To attempt to reestablish a general, comprehensive health service clinic in the Glades area for migrants only, and compare the results of the present system of providing care in this area. The out-migrants in the Glades are content with the present system in that they have permanent homes here, and prefer going to the same physician they have used for many years. When they are working, many readily pay for their own medical care. This is in contra-distinction to the Eastern "Rangeline" area, composed mostly of in-migrants, who have never established this relationship.

B. Inpatient Hospital Care.

Arrangements:

Operation of the program began officially on August 16, 1967, after budget funds were released. A health field worker was employed to work out procedures with participating hospitals as well as investigate and verify migrant status. Various forms necessary for proper record keeping were designed and developed, and organizational procedures adopted. All hospitals in Palm Beach County were visited to explain the nature of the program and to invite their participation. Five of the area hospitals submitted signed written agreements and began participation immediately. A sixth hospital, located in another county, submitted an agreement at a later date. At present there are two non-participating hospitals in Palm Beach County. Copies of agreements are on file at the Health, Education and Welfare Regional Office in Atlanta, Georgia; the Florida State Board of Health at Jacksonville, Florida; and at the Palm Beach County Health Department in West Palm Beach.

Procedures:

The Health Field Worker in charge of migrant status verification is notified by the hospital of persons admitted, and by the Palm Beach County Health Department migrant clinics of persons referred by them for present or future hospital admissions. These persons are then interviewed and their status as a migrant determined. The possibility of financial resources, such as insurance, etc., is explored. Both the public health nursing section and the social work service of the health department are notified of each case. The migrant verification form (4964) is completed and sent to the hospital, which takes responsibility for completing the admission and charges report (4965) and having it signed by the patient. Copies of both forms are returned by the hospital to the health field worker, who records certain information, then forwards them to the business office. This office calculates the amount of hospital charge to be paid, and forwards completed copies of both forms to the State Board of Health in Jacksonville and to the H.E.W. Regional Office in Atlanta, Georgia. The State Board of Health then issues a warrant for the amount of the payment and sends it to the Palm Beach County Health Department's business office, which forwards the warrant to the hospital.

Agencies such as the State Vocational Rehabilitation Service, Council for the Blind, and others are notified of patients needing their special services.

Experience:

Prior to the beginning of the project many migrants with chronic conditions, such as a hernia, were improperly cared for, and because of this were unable to adequately care for themselves or their families. As these people became aware of the hospital service, they sought treatment and the hospitals, assured of a remittance, did not hesitate to admit them.

Some complaints were registered by doctors who felt that their fee should also be paid, but as a general rule the rough road of illness has been made smoother for both migrant and hospital.

A most pressing and frustrating problem is the absence of funds and facilities for the post hospital care of patients. A person with a severe heart condition or who has been paralized by stroke or accident, not to mention the convalescence necessary in less severe cases, must receive care, but in many instances this care consists only of an inadequate shelter, a ragged bed, and lonely suffering.

Changes Made:

Because of the overwhelming number of persons requiring hospital care, and an inadequate budget to meet these needs, discrimination of cases toward the end of "the season" by setting priority was necessary.

Changes Needed:

a. To meet the hospital needs of the migrants, a more adequate budget must be provided and some method devised for post hospital care above and beyond the organizational services that now exist.

b. Funds should be budgeted to reimburse physicians on a reasonable costs basis. This is one factor that is missing.

c. An amendment to the 30-day limitation on hospital care is needed to provide care for certain patients requiring extended service in or out of the hospital.

An example of this is an accident case in which the spine of a young patient was severed, causing lifetime immobilization and special care. After 2½ months in the hospital, a relative was located in South Carolina who was concerned enough to take the patient into his home.

A second example is a male patient who suffered complete paralysis through a massive stroke. After many weeks in the hospital, beyond the 30-day period, the welfare department in Puerto Rico accepted the case and the patient was sent there by plane.

The point is that both patients were sent out of an area in which they wished to stay, and this procedure did not resolve the problem, but merely shifted the burden and responsibility to other areas. Neither patient was eligible for the local area's limited extended care facilities because they were non-residents.

C. Other health care activities.

1. The school board, through Title I., E.S.E.A., again this year provided intensive education services to approximately 200 migrant kindergarten school children. Medical and dental services for these children, under the direction of the health department, were provided by local pediatricians, and follow-up care by appropriate medical and surgical specialists. Dental care for these youngsters was provided by the public health dentist in the new migrant dental trailer.

In Delray Beach, a special night family planning clinic was established for all indigent women in the south-county area. Many "Rangeline" migrants availed themselves of these services. Personnel involved here were a physician, a public health nurse, and a nurse's aide.

2. Personnel involved.

The personnel are described in narrative above.

3. The changes from previous year.

   The changes in health care activities have been enumerated in the narrative previously, mentioning changes in health care in the "Glades," the new dental trailer, family planning clinic, etc.

4. Changes needed in future and reasons.

   This category was spelled out under II.A.7., in the preceding section of the narrative, under "Future changes in medical and dental services."

D. Relationships with community groups.

1. The relationship with growers has always been excellent in the area of health services, but strained in the area of sanitation. However, the relationship in this area has improved as they realize the result of improved housing and sanitation in being able to retain the more reliable worker. Another factor in improved relations by growers is the increase in the number of field privies provided by the growers, a sanitary facility considered as not necessary in past years.

2. Welfare (Title XIX): Florida does not participate in Title XIX as the State Legislature failed to appropriate any funds for this program in 1967. It is programmed to go into operation in 1972. The relationship with both the State and County Welfare Departments is excellent. Case workers attend the clinic in Hillville and the Glades in order to give assistance to the migrants who qualify. Surplus foods are provided to all migrants that are in need.

3. Medical Society: The Palm Beach County Medical Society supports the objectives of the Migrant Health Project and cooperates with the program.

4. All the services of the health department are available to migrants. The department conducts a generalized public health program and has established clinics throughout the county that are available to migrants. Weekly chest clinics are conducted in three areas that are accessible to migrants.

5. Day Care Centers: Public Health Nurses visit the day care centers in the county on a routine basis. However, there are only three day care centers in the county that care for migrant children at reduced rates. The majority of the day centers are privately owned, and the fees are too high for the migrants to afford day care for their children. The availability of day care centers for migrant children is a deficiency that needs critical attention.

6. Continual contact has been maintained with the Farm Labor Office of the Florida State Employment Office to keep abreast of expansion and changes in the yearly crop picture, the movement and recruitment of workers, and other factors relating to migrants. The Farmers' Home Administration is contacted for determining loan requirements and other

related information. Vista workers are used when available in clinics and on the mobile x-ray unit when the unit is used in mass survey for tuberculosis.

7. Migrant Legal Aid of Southeast Florida, Inc., is a new agency funded by O.E.O. to provide legal service to migrants. A working relationship has been established with this agency by referring migrants to them for legal assistance, and they, in turn, seeking medical and housing assistance from us. There is a mutual exchange of services and referrals between the two agencies.

8. Crew leaders and key individuals in larger labor camps are contacted for assistance in locating migrants that fail to keep appointments to chest, heart, V.D., and other clinics. Only one tuberculosis suspect was not located last year as compared to four or five in previous years.

9. Agreements have been formulated for referrals and for inpatient hospitalization with other projects in Broward and Dade counties.

10. The American Friends Society, with project personnel, planned and assisted in the operation of special family planning clinics.

E. Consultation received from outside local project area.

   1. Type and source.

      a. Statistical analysis.

      Assistance and consultation on the techniques of random sampling by the health program analyst from the Migrant Health Branch of the U.S.P.H.S. was received. The sanitation staff used this information to project the age and sex distribution of the migrant population in the county.

      b. Health education.

      The health educator on the statewide migrant health project consulted with staff members on planning education programs for migrants.

      c. Hospitalization.

      Consultation on procedures and methodology in handling the hospitalization program for migrants by the regional migrant health representative resulted in a smoother operation.

      d. On rare occasions, when unusual medical problems are encountered, the patient is transferred to the medical centers at the University of Miami or the University of Florida in Gainesville for consultation and treatment.

F. The resources of the Palm Beach County Health Department are so well developed that no consultation or assistance is needed for the development of new systems or provision of health services, except as indicated in E.

G. Orientation or in-service training.

All new personnel employed by the health department, regardless of their funding, are required to attend formal orientation and in-service training sessions, depending on their discipline. Public health nurses have a three-week program. The purpose of the orientation and in-service training is to acquaint the employee with all of the functions and services of the health department; instill in the employer the concept and philosophy of a generalized public health program; to familiarize the employees of the objectives of the special projects; to become acquainted with all of the community resources available to the health department. In addition, employees are sent to a three-day orientation program, sponsored by the Florida State Board of Health and conducted by the Division of Health Education. No employee is given added responsibilities until he has satisfied his immediate supervisor. As this is a standard operating procedure in the department, no immediate changes are planned or anticipated. Key staff members attend two out-of-town conferences on migrant health.

III. General appraisal of year's achievements.

A. Degree to which objectives were achieved.

1. Family health service clinics.

   a. The family health service clinic in the Eastern "Rangeline" area of Palm Beach County reflected an increase of 9.4 per cent in the number of individuals seen in clinic, and an increase of 10.2 per cent in the number of clinic visits despite a decreased number of clinic sessions.

   b. The family health service clinic in Pahokee began operation in July and continued to function for a period of six months, but had to be discontinued and was replaced by a triage clinic held daily from 9:00 to 10:30 in the morning. See A - Medical and Dental Service for specific information.

2. Hospitalization program.

   a. The hospitalization program began to function in August, 1967, after funds were released.

   b. There are no funds to pay physicians, and this remains an unmet need.

3. Public health nursing service.

   a. There was a substantial increase in the number of individuals as well as in the patient visits to clinics, despite a decrease in the number of clinic sessions.

   b. By the same token, there was a decrease in the number of field visits by nurses this reporting period.

4. Dental care.

There was an increase in the number of migrant children and adults receiving dental care as a result of the Palm Beach County School Board being awarded a project under Title I., E.S.E.A., which has provided a specially designed, constructed, and equipped mobile dental unit. The project is responsible for staffing and operating this dental clinic, and funds appropriated for dental care in the project budget were used for this purpose. The unit was located in the Western, "Glades" area, since it began to function in December, 1967. Plans to locate the dental unit in the Eastern, "Rangeline" area, are not as definite as originally planned. The health department has employed a consultant dentist who will be responsible for developing a total dental care program, utilizing all the dental resources available to the department - which includes two dental clinics as well as the mobile dental unit.

5. Sanitation.

6. Health education.

   Refer to "Health Education Section."

B. Problems encountered in achieving objectives.

1. Administrative problems.

Vacancies in public health nursing, sanitation, and health education positions, caused by resignations, remained unfilled for several months due to inadequate salaries and a shortage of qualified personnel. A public health nurse is scheduled to be employed in August, 1968. The health education position was filled in December by a health educator that was not public health oriented. The prospects for filling the sanitarian positions are very good.

Despite these vacancies, every effort was made to implement the objectives as stated in the project plan. By assigning other staff to related duties and utilizing non-project personnel, many of the objectives were carried out.

There was an unavoidable delay in remodeling the Hillville Rural Clinic that is located in the center of the migrant area along the Eastern "Rangeline" area. This sub-station has been partitioned to provide office space for the project staff and an area suitable for group education and waiting room.

Family clinics.

1. The resignation of the private physician in charge of the clinic that was established in Pahokee necessitated an adjustment in health services to migrants. Instead of weekly night clinics, a daily triage clinic was established that provides health service to the domestic agricultural worker. It is able to function with the cooperation of the practicing physicians in the "Glades" area, and this service meets the needs of the workers in this area.

2. The night clinic at Hillville in the Eastern "Rangeline" area

was closed for a period of six weeks due to a report that the migrants were planning lawless action against the owner of the building housing the migrant clinic. Upon consulting with the Office of the County Solicitor, it was decided to close the night clinic to avoid any trouble. Despite this temporary cancellation of the clinic towards the end of the season, there was an increase of 16.2 per cent in the number of patient visits.

Sanitation

The slow process of obtaining legal action remains a problem in achieving all of the objectives in housing and environment.

Unfilled vacancies in sanitation staff positions remains a problem that continues to hamper implementation of all the sanitation objectives.

Health Education

The orientation and in-service training of a new health educator reduced the effectiveness of the health education effort as indicated in the section on health education.

Hospitalization

Insufficient funds to meet the hospital needs of migrants was a problem that required setting of priorities of need. The lack of funds to pay physicians' fees remains a problem that will continue to hamper the objectives.

C. Strong points in achieving objectives:

1. The alterations to the substation in the Eastern "Rangeline" area to provide delineated office areas for the project staff, including public health nurses, sanitarians, aides, the health educator, as well as space for group education. The latter is the first time in the project's history that space for this puppose exists.

2. Acquiring specific audiovisual equipment that will enhance the education objectives.

3. The centralization of sanitation, nursing, medical and other records making them readily available to project staff.

4. The establishment of a triage "sick call" clinic in Pahokee and Belle Glade in the Western area of the county which provides family health service to the domestic agricultural worker.

5. The cooperation of the practicing physicians in the "Glades" area in providing medical service.

6. Inpatient hospitalization for migrants funded by the project. This has made it possible for the acutely ill and injured migrants to be admitted to the area hospitals, and has relieved a portion of the financial burden experienced by the private hospitals in the care for indigent migrant patients.

7. The inauguration of dental service by obtaining a mobile dental clinic. This mobile unit was purchased by the Board of Public Instruction under Title I., E.S.E.A., Migrant Project Grant, and is operated and staffed by the Migrant Health Project.

8. The teamwork and dedication of project staff reflected an increase of 10.2 per cent in patient visits, and a 9.4 per cent increase in the number of patients seen in clinics; also, an increase to 78 per cent the number of labor camps permitted.

9. Bilingual project personnel, professional as well as non-professional, have generally solved the language problem. The health educator, one public health nurse, and the MIC nutritionist, being Negro, have lessened the communication gap.

10. Random sampling of over 10 per cent of the in and out migrants, projects the age and sex distribution of the migrant population operation.

11. The operation of a special family planning clinic in the southeastern area of the county available to migrants.

D. Plans for overcoming weaknesses.

1. The family health service clinic in Pahokee was established, but had to be cancelled due to the resignation of the clinic physician and public health nurse. It was replaced by a triage "sick call" clinic held one hour a day, five days a week.

   Recommendation: Reestablish the family health service in Pahokee if it is found the triage clinic is not successful and if medical and nursing staff is available.

2. Staff vacancies.

   Plans are currently to actively and agressively recruit qualified personnel to fill all existing vacancies in sanitation and public health nursing. The State Personnel Board is planning to upgrade salaries and provide realistic fringe benefits that will materially improve the recruiting and retention of personnel.

3. Random sampling of migrant population: A random sampling of at least 25 per cent of the migrant population during the peak months of January and February will be undertaken in order to project more accurately the age and sex distribution of the migrant population in Palm Beach County.

4. A sanitation aide should be employed for the coastal area to provide assistance in the following areas:

   a. Random sampling of migrant population.
   b. Health education services.
   c. Routine sanitation activities in connection with the inspection of camps and non-camp housing.
   d. Other related duties in connection with project activities.

5. Physicians' Fee and Hospitalization.

The resident requirement precludes the spending of local tax monies for hospitalization and physicians' fees to indigent migrants. As this is a legal matter, no plans can be formulated by this project to overcome this weakness. The Governor's Study Commission on Migrants, however, is formulating statewide plans that may attempt to bring about a solution to these problems.

6. Legal Service.

In order to provide prompt legal action on matters pertaining to the enforcement of the State Sanitary Code, it is recommended that an attorney be employed or retained for legal consultations and obtaining injunctions against violators of labor camp regulations when all attempts at education and persuasion have failed. Initial plans for funding in the county's budget have been discussed.

7. Health Education.

In order to strengthen the health education effort, and individual has been employed and is being oriented to public health, and assigned on-the-job training in preparation for graduate study in health education.

IV. Specific Plans for Future.

A. Objectives.

The objectives stated in the project plan will be modified, altered, and changed to meet the health needs of migrants wherever changes are indicated.

1. Family Health Service in "Glades."

The triage clinic established in January, after the night clinic was cancelled, is a case in point. If evaluation of existing health services prove inadequate, and the migrant situation in the "Glades" changes, a family health program similar to the Eastern "Rangeline" area will be established.

2. Dental Health.

A consultant dentist has been employed by the health department to develop and implement a countywide dental care program that will provide dental care to all migrant and non-migrant indigents.

B. Medicaid, Title XIX.

The State of Florida plans to participate in Medicaid, Title XIX, by 1972. The health department is making plans to implement Medicaid when it is adopted. The health department is presently approved as vendor of services under Medicare. With the experience gained in this program, no difficulty is anticipated when Title XIX is adopted. Plans for providing health services to migrants are underway with State Welfare and Health officials.

C. Procedures.

With Palm Beach County formulating a countywide water and sewerage treatment, collection, and distribution system, the procedures for reviewing and approving plans for labor camps and housing for migrants will have to be modified in order to comply with regulations that will be adopted. At present, the Director of Environmental Health and the Director of Sanitation are working closely with consulting engineering and Planning Board members on plans for the implementation of this huge project. It is too early to give specific details as complete engineering plans have not been adopted.

D. Relationships.

The completion of each project year reveals the importance of harmonious staff. As new staff members fill the vacancies created by retirement or promotion, the established relationships change. Working relationship must be modified to make certain that the program to achieve the objectives is in balance. Staff meetings and conferences are planned and held on a monthly basis to exchange ideas, discuss possible solutions to new problems, and to mold the staff into a smoothly operating team.

E. Staff.

1. A sanitation aide to be added to the staff and assigned to the "Coastal" area to assist the sanitarians:

    a. in non-camp housing sanitation programs,
    b. in random sampling of migrant population,
    c. to perform other routine duties that are non-technical.

2. Use of equipment operator for transportation of patients to clinic, hospital, and other related facilities.

3. A clinic aide to be assigned to the "Coastal" area for use in the expanded clinics that are planned. These Aides should be bilingual so that they can be used in making home and field visits, as required.

    (Refer to future plans in Nursing, Sanitation, and Health Education sections for more details.)

NURSING

I. General description of nursing service.

A. Staff

1. Professional:

    Public Health Nurse Supervisor
    Public Health Nurse III
    Public Health Nurse III
    Public Health Nurse III (Vacant)

2. Non-professional:

1 Clerk-Typist III
2 Clerk-Typist II
1 Equipment Operator

A public health nurse III has been recruited to fill the vacancy that occurred in mid-season. It is anticipated that the PHN III will join the migrant project staff in August, 1968.

All the above positions are funded by the project.

Volunteers were available from:

a. A health aide from the American Friends Society family planning clinic assists with casefinding and patient referrals; also acts as interpreter for Spanish-speaking patients.

b. Two Junior Red Cross volunteers working in clinic during summer, weighing patients and assisting with movement of patients to physicians.

c. Approximately ten seminarians served as interpreters and looked after small children while parents were seen by the staff.

B. Specific objectives and duties.

1. "To provide total family oriented public health nursing services to the migrant population in Palm Beach County in cooperation with existing health department programs and the Maternity & Infant Care Project. Public health nursing to include:

   a. Public health nurse field visits for health supervision and casefinding on a regularly scheduled basis to:

      (1) migrant camp area,
      (2) non-camp, migrant housing within municipalities.

   b. Home health care under medical direction for acutely or chronically ill on referral by area hospitals, physicians, and clinics.

   c. Intensive public health nursing services to schools with a high migrant student enrollment.

   d. Planning and implementation of group health educational activities adapted to the migrants.

   e. Regular public health nurse visits to all area hospitals with migrant patients for coordination of services and continuity of care."

2. Duties.

   The public health nurses provide a generalized public health nursing service through field visits and clinic sessions.

   a. Assess the health needs of migrants attending clinic or seen through home visits, and seek their cooperation to avail themselves of the health services that are provided.

b. Refer migrants to other agencies providing service to migrants.

c. Provide consultation and advice on family planning.

d. Participate in health education activities for migrants.

e. Perform other public health nursing functions as required.

f. Attend conferences and seminars to keep abreast of new concepts and skills in providing health services to migrants.

The aides assist the nurses during clinic sessions, and perform other related duties as required, including field visits. The bilingual aides act as interpreters when needed.

The equipment operator is responsible for moving the mobile clinic, when necessary, and provides transportation for patients. The equipment operator is responsible for first echelon maintenance of vehicle and mobile clinic.

C. Relationship with migrants, growers, and others.

1. Key migrants in camps and other housing are sought out and contacted for assistance in defining health needs of migrants. Liaison with crew leaders is maintained for continuity of care and referrals to agencies outside of project area. Growers are tolerant of public health nurses but complain of the number of persons and agencies trying to see migrants while working.

2. The public health nurse supervisor is a member of the Migrant Aid Committee of Palm Beach County and the lay committee for Migrant Adult Education.

3. Conferences and meetings are held routinely for all project staff for the exchange of ideas on programs serving migrants. The housing of all the migrant project staff in the Hillville substation has improved the relationship between staff nurses, migrants, and growers.

4. Nursing personnel are frequently asked to speak to various community groups regarding the migrant health program.

D. Consultation received from outside project.

The medical social worker and nutritionist from the Maternity and Infant Care Project provide consultations to staff and patients. They attend clinic, and are available when needed.

E. Consultation needed from outside.

Improved systems on data collection for statistical purposes are needed.

II. Services provided to migrants.

A. General description of nursing services to migrants and families.

(Refer to Plates A and B for pictures on nursing services in clinic.)

1. In clinics.

   a. All services of a generalized public health program are offered to the migrant. The clinics are family oriented, and an attempt is made to meet the needs of each patient.

      (1) Instructions are given in maternity care.
      (2) The prenatal is advised on diet, personal hygiene, exercise, preparation for entering the hospital, and interpretation of the doctor's examination.
      (3) For the postnatal patient, information is available for general health care, and instructions are given for various types of family planning procedures.
      (4) The infants and pre-school children are offered complete physical examinations, immunizations, and parents are given instructions in feeding.
      (5) Morbidity cases are given instructions in diet, hygiene, etc., according to individual needs. During the last season, a great many diabetics were seen. They were taught to test urine, using Testape to record same, and bring the results on their next clinic visit.
      (6) Medication is provided in clinics under doctor's instructions.

2. In the camps, fields, etc.

   a. Nurses visit in the camps on a weekly basis, seeking out newcomers and doing follow-ups as indicated after clinic visit, hospital or private doctor's referral.

      Example: One camp in which three cases of tuberculosis was discovered has had special attention for contact investigation and casefinding. As a result of this contact investigation, 90 residents of this camp were skin tested for tuberculosis by using the PPD test. Fifty-eight (58) of those tested were positive reactors, and were placed on medication with INAH. Out of the 58 positive reactors, one definite case of tuberculosis was uncovered, and the patient was admitted to the Southeast Tuberculosis Hospital, which is located in Palm Beach County.

   b. The nurses visit patients in the fields only on special occasions as the farmers object strenuously to the workers being disturbed at work.

   c. The nursing staff has been involved with the two migrant kindergarten projects in the county, as resource people, and also assisted with follow-up.

d. There are no approved day care centers in the "Rangeline" area; however, the day care center in Belle Glade receives generalized nursing service from the staff public health nurses in the "Glades."

B. Health education as part of service.

Health education is an active part of the nursing service. Fifteen to twenty minute talks have been given on Family Planning during clinic sessions. Every patient seen in clinic has a conference with one of the public health nurses. Plans are being formulated for some type of film to be shown at each clinic session. The health educator is working closely with the nurses to plan more effective programs for migrants.

C. Referral system used locally.

Locally, patients are referred for service by using local agency forms, if available. If not, appointments are made for patients, either by phone or letter, and patients are given a note with specific instructions for finding the place of referral and date and time of appointment. Sometimes maps are drawn for the patients. On occasion, our own interpreter has been sent with a patient if the language barrier has been a prohibiting factor. If the patient is not really motivated, he will not follow through. Some employers are not willing to allow the patients to leave their jobs, and when other work is available, patients will not lose a day's work.

D. Referral system used for out-of-state.

The zip code Migrant Health Service Referral Form is used for out-of-state referrals when applicable. Otherwise, letters are written to the appropriate agency for follow-up. An effort was made this year to use more effectively the U.S.P.H.S. Personal Health Record, and to impress on the patient the value of carrying it with him.

The main reasons for incomplete referrals are the lack of adequate address, and the mobility of patients. Many leave the area on a day's notice and have no idea of where they are going.

III. General appraisal of nursing program.

A. Strong points:

1. The renovation of the Hillville Rural Clinic, located in the center of the migrant farm area in the coastal section of the county, has improved the nursing service available to the migrants by:

   a. Providing easier access for patients to nursing service.
   b. Improved clinic facilities.
   c. Providing space for group health education activities.
   d. Encouraging closer relationship with the project personnel.
   e. Centralizing all health records in one office.
   f. Reducing travel time for field visits and patient follow-up.

2. Transportation provided by project vehicle assures better continuity of nursing care.

3. The hospitalization program has provided the necessary health need that was not available in previous years.

4. The use of bilingual physicians and ancillary workers has lessened the communication gap.

5. An appointment system was started for clinic service this year, resulting in approximately 60 per cent of the appointments being kept.

B. Weaknesses of service:

1. The increased attendance in both the night and day clinics has lessened the time for field work because of the necessary patient follow-up that is required.

2. There still remains a communication barrier between some of the ethnic groups.

3. The innate fears, superstition and mores regarding health services and needs remains a major weakness.

4. Insufficient addresses and lack of adequate identifying information as to the migrants' destinations.

IV. Plans for the future.

A. Consider the possibility of an additional night clinic to better meet the needs of migrants and reduce time of existing clinics which often extend past midnight.

B. Reorganize staffing pattern to allow for additional night clinics without involving all the staff for every clinic.

C. Increase use of home health aides in clinic services and home visits to free nurses for other nursing functions.

D. Initiate public health nursing conference hours on scheduled basis in large camps and other concentrated areas to encourage patients to seek help at convenient locations.

E. Intensify effort to obtain more accurate statistics, not only in the Migrant Project, but throughout the generalized program by identifying services performed for the migrant population in all programs.

F. Improve coordination of activities of all agencies serving the migrants. These will include Community Action Fund and their volunteers, the American Friends, Christian Ministry to Migrants, and public school programs; including Migrant Kindergarten and Adult Education.

SANITATION

I. General description of sanitation service.

A. Staff.

Sanitation services were provided by a sanitarian supervisor, three senior sanitarians (one senior sanitarian position was vacant throughout the season), and one sanitation aide all of whom devoted 100 per cent of their time to the migrant project. Other sanitation and engineering services were rendered by the general staff of the health department as occasions demanded.

LIST OF PERSONNEL AND PER CENT OF TIME ON PROJECT

Health Officer (Director)	5%
Assistant Health Officer	10%
Health Program Specialist	20%
2 Public Health Engineers	10%
1 Sanitation Director	25%
1 Sanitation Supervisor II	100%
1 Sanitation Supervisor I	20%
4 Senior Sanitarians (one vacant)	100%
3 Sanitarians	20%
1 Sanitation Aide	100%
1 Administrative Assistant	10%
1 Equipment Operator	100%
2 Clerk-Typist II	100%
1 Clerk-Typist III	100%
2 Clerical Personnel	10%
3 Custodians	10%

B. Specific Objectives and Duties.

To conduct a migrant housing program covering all types of housing used by migrants and using all available resources to achieve maximum standards of environmental sanitation. The sanitation services to include:

a. Consultation and guidance to growers, health department staff members, personnel of other agencies, and others concerned with migrant sanitation.

b. Inspection, consultation and evaluation of findings on periodic visits to migrant labor camps, rooming houses, and other migrant housing, making recommendations for improvements as indicated.

c. Consultation to growers and others in regard to migrant housing design and construction.

d. Advisory and instructional services to migrant workers and families in all types of housing to improve their standards of environmental health.

C. Work to be done and proportion of work accomplished.

The major work to be done toward meeting sanitation objectives consists of the following:

1. To bring the remaining unpermitted camps up to standard, and to maintain an acceptable level of camp cleanliness throughout the season.

2. To obtain improvements in non-camp housing, such as rooming houses where the major problems are a lack of proper cooking facilities and poor maintenance of living quarters and sanitary facilities.

3. To bring about improvements in the working environment of farm workers, which will include toilet facilities, handwashing facilities, drinking water, and food service.

4. To encourage growers and camp operators to provide a better living atmosphere for the workers and their families, which will include proper maintenance, and the provision of recreation facilities.

5. To provide educational services to migrants directed at improving their standard of sanitation practices.

6. To work with personnel of other agencies and organizations in securing proper living quarters for migrants.

Major accomplishments include the following:

1. Even though one critical sanitarian position remained vacant throughout the season, all camps were visited and efforts were made to bring all unsatisfactory camps up to standard. Of the 28 camps not meeting standards, 13 are making progress toward approval; nine (9) are to remain closed after this season; two (2) have legal action in process against them; and legal action may be necessary against the remaining four (4). One-hundred, four (104) camps, or 79 per cent, now meet standards compared to 74 per cent last year and 32 per cent four years ago.

2. An inspection program has been set up to improve living conditions in 415 rooming houses where over 8,000 migrant workers and their families lived during the past season. A total of 914 visits were made to these rooming houses during the past year though another state agency (Florida Hotel and Restaurant Commission) has the responsibility for the enforcement of rules and regulations in housing of this type. The sanitation aide worked closely with rooming house managers and occupants in promoting cleanliness of the premises, especially maintenance of central sanitary facilities.

3. Progress was made this year in the provision of sanitary facilities in field locations. While nearly all locations had provision for drinking water, very few provided toilet facilities and even fewer had provisions for handwashing. A total of 124 field locations were visited this season and discussions took place with growers, farm managers, and crew leaders regarding ways and means of providing proper sanitary facilities for field workers. This category is covered in more detail under Item III.

4. Attempts were made to encourage growers and camp operators to improve the living environment in labor camps by providing recreation facilities and making the premises more attractive. Project sanitarians assisted the operators of ten camps in mixing a cheap paint using quick lime, white cement, parafin, etc., which was applied inside and outside

the structures. In all cases the improved appearance of the buildings led to further improvements to the premises; such as landscaping and structural repairs. At the end of the season most of these camp operators reported far less damage to facilities and a better work force.

5. Progress in providing direct educational services to migrants has proceeded slowly and will be discussed under Item IV of this report.

6. Personnel of other agencies were consulted frequently throughout the year regarding the planning, construction, and financing of housing and enforcement of regulations pertaining to housing. Refer to Item I-D.

D. Types of individuals and groups with whom working relationships were established.

   1. Palm Beach County and various city building and zoning departments which were consulted on individual problems, particularly in areas where their regulation is more pertinent than ours.

   2. Florida Farm Labor Office which assigns formal crews of interstate farm labor to camps.

   3. Florida Hotel and Restaurant Commission with which agency the health department coordinates activities relating to inspections of rooming houses.

   4. The Community Action Fund, a county-wide division of the O.E.O. program. Inter relationships with this agency define policy and prevent duplication of services.

   5. The South Florida Migrant Legal Service, a federally funded organization that works closely with migrants in solving some of their legal problems.

   6. The U.S. Department of Labor whose local pepresentative assists in the enforcement of joint state and federal standards for camps that house off-shore workers.

   7. The British West Indies Labor Organization has three representatives in Palm Beach County who also coordinate with project staff in areas which concern off-shore contract labor.

   8. The Florida Christian Migrant Ministry administers child care centers at two large labor camps and helps to further mutual efforts to obtain improvements at these centers.

   9. The Office of the County Solicitor, Palm Beach County, is counsulted for advice and legal assistance on substandard camps.

   10. The Lake Worth regional office of the Farmer's Home Administration, U. S. Department of Agriculture, is currently processing applications for federal financing related to camps and other farm labor housing totaling over five-million dollars.

11. Individual engineers and architects frequently consult project personnel regarding the preparation of plans which involve camp construction and/or renovation.

E. Consultation obtained from outside project.

1. County Solicitor's office - this agency was consulted frequently regarding legal procedure to be followed in dealing with camp operators who failed or refused to bring their camps up to standard. Three cases are being processed by this agency at the present time.

2. County Building and Zoning Department - advice and assistance was obtained from this department regarding structural standards and location of migrant housing.

3. Bureau of Sanitary Engineering and the Division of Sanitation, State Board of Health - provided consultation regarding sanitation standards for housing and related facilities and work locations.

F. Legal consultation and direct assistance is needed in order to cope with the complex legal problems that arise in dealing with labor housing. The only solution seems to be in retaining the services of an attorney to represent the health department, or employing a staff attorney full time. At this time the State Board of Health cannot provide the required legal assistance.

II. General description and condition of housing accommodations for migrants.

A. Nearly all of the labor camps built for migrants in the last ten years are of block construction which now represents 50 per cent of the total camp housing. Forty-two per cent of the remaining housing is of frame construction, seven per cent is metal, and one per cent of the camp occupants live in house trailers. Block construction is far easier to maintain and complies more readily with building codes than frame or metal. With frame construction, maintenance becomes quite a problem; therefore, the trend is toward the replacement of frame structures with block. (See pictures - Plates D and E.) Another noticeable trend is the increasing demand for family units and the decreasing demand for single male quarters. Cooking operations continued to be a problem in a large number of dormitory rooms without proper facilities.

Increasing numbers of migrant families are seeking housing in urban areas in preference to labor camps.

B. Analysis of Table A.

1. The authority for the issuance of permits for labor camps stems from Florida Statutes which also enabled the State Board of Health to adopt regulations relating to the operation of labor camps. Legal standards for non-camp housing are somewhat fragmented and consist of Florida Hotel and Restaurant Commission regulations which apply to rooming houses and apartment buildings, county buildings and zoning regulations which apply to new construction, and State Board of Health regulations applying to sanitary facilities and waste disposal.

2. The following factors have contributed to improvements in overall housing situations:

    a. The education of growers, camp operators, and others concerned with housing as to the need for a better living environment for migrants.

    b. The improvements in inspection and enforcement techniques by sanitarians.

    c. The recognition by growers that better housing attracts better workers.

    d. Migrants are beginning to demonstrate a desire for better living facilities and are better able to pay for them.

    Even though progress is evident in the overall housing situation, problems are being encountered in the maintenance of some housing facilities during the growing season. One of the main factors is the lack of effective supervision in some of the labor camps. Most growers state that they do not have time to pay much attention to housing facilities during the season and that good supervisors are difficult to find. These growers had rather let things go during the season and repair the damage during the summer, which not only creates poor living conditions, but causes unnecessary expense which preventive maintenance could have avoided.

C. Analysis of Table B.

1. General description of water, sewage disposal, garbage and refuse disposal, and refrigeration:

    a. Water - while Palm Beach County is blessed with an unlimited quantity of bacteriologically safe water, the chemical quality of most of the ground water leaves much to be desired. Some of the more objectionable characteristics are iron, sulfur, and chlorides. All new camps are required to retain an engineer to design water supply and sewage disposal facilities. (See picture - Plate F.) Water treatment in these cases range from continuous chlorination to complete treatment including softening. Approximately 71 per cent of camp occupants and 76 per cent of migrants living in non-camps housing are served by treated water. A large percentage of the remaining untreated water supplies create problems due to taste, color, odor, and staining of plumbing fixtures and utensils.

    b. Sewage Disposal - A total of 109 labor camps with a capacity of 24,513 are now served by flush toilets with approved sewage disposal facilities. This represents 83 per cent of the camps housing 92 per cent of the total camp occupants. The increasing number of camps served by flush toilets reflects the health department's policy of requiring flush toilets for all new construction and for existing camps where major remodeling is required in order to meet present standards. While privies may be considered feasible for areas where the growing season is very short, they are definitely unsatisfactory for home base areas even where maintenance is normally satisfactory, due to odor and to the difficulty in protecting the contents from flies and other vermin. Seat lids will seldom be kept closed and odors are difficult to control. While maintenance of central flush toilets is a definite problem, there is less of a health hazard due to the proper disposal of the waste and also an opportunity to teach migrants to use and desire modern plumbing facilities.

Twenty-one per cent of the labor camps have central sewage treatment. These are the larger camps with a total capacity of 15,680 or 60 per cent of the total capacities (See picture - Plate F).

c. Garbage and refuse:

Garbage and refuse disposal presents one of the most serious problems in migrant housing. Even where garbage is collected by a franchised company, proper storage remains a problem. The operators of the smaller camps complain that garbage cans get damaged through misuse or disappear altogether. It is difficult to get occupants to make use of the garbage cans and even more difficult to keep the cans properly covered. Most of the larger camps use dumpster units furnished by the garbage company. The location of these units sometimes is inconvenient for the occupants, resulting in the dumping of garbage on the ground.

Records for the season showed that 71 of the 132 camps subscribed to franchised collection; 46 camps hauled their own in a satisfactory manner; and 15 used and unsatisfactory method of disposal, usually burning it on the premises.

Approximately 75 per cent of the non-camp housing locations were served by franchised or municipal garbage service since the majority of these locations are in Belle Glade, Pahokee, and the suburbs of coastal cities.

Another problem is in disposing of old automobiles that are abandoned by migrants each season. These old cars are unsightly, provide harborage for insects and rodents, and interfere with mowing of grass and cleaning of premises.

Since these cars are generally stripped of most salvagable parts, the junk dealers hesitate to take them. This season, through the cooperation of other county departments, arrangements were made to have a salvage company remove these cars from several of the larger camps. At one of these camps, operated by the Pahokee Housing Authority, over 100 old cars were hauled away.

d. Refrigeration:

Labor camp regulations state in part that "in camps where individuals or families are permitted or required to cook within their living quarters, provision shall be made for refrigeration of food." Approximately half of the camps offering family quarters provide refrigerators, as well as other kitchen equipment. In the remainder a stove is usually provided, but the occupants provide their own refrigeration. Many migrant families, especially where few children are involved, choose to buy perishable foods meal by meal.

Commissaries and other stores are generally convenient to all housing facilities. It is estimated that at least 90 per cent of all family units now have an electric refrigerator, this in complete contrast to conditions of ten years ago. The most common problem in lack of refrigeration exists in the rooming houses where families choose to cook in sleeping rooms with or without permission of the operator.

2. Adequacy of food handling practices, insect and rodent control, recreational facilities and general cleanliness in camps.

   a. Food handling practices.

   In camps where central feeding operations are conducted the occupants generally fare better than where they prepare their own food. All camps with a central mess now meet restaurant standards for equipment and structure and all personnel are required to have health cards. Despite the regulations and educational efforts, food handling techniques in the smaller camps and in family kitchens is frequently poor and a good level of cleanliness is hard to maintain. However, there have been no cases of food poisoning reported, probably due to the fact that few hazardous type foods are served in labor camps and the migrants have possibly developed a certain amount of resistance to bacterial infections.

   More educational efforts are needed to teach migrants proper food handling techniques and to use foods that provide a more balanced diet. The conversion of dormitory facilities to family quarters has not kept pace with the demand as mentioned in II.A. of this report. Where cooking operations are conducted in sleeping rooms, food handling practices are generally poor due to the lack of proper facilities.

   b. Insect and Rodent Control:

   The control of rodents and insects in labor camps and other migrant housing locations is a continual problem. The most prevalent insects are flies and roaches. These are the most difficult to control due to poor food handling and garbage disposal methods. Roach infestations become so severe that some migrants resort to the use of deadly parathion as a control measure. This pesticide is effective against all insects, rodents, and even snakes and is extremely hazardous to use around living quarters. Several cases of poisoning are reported each season due to the use of parathion by migrants in their living units. There was one death reported this season. The victim was an 18-month-old child who apparently was exposed to the poison while playing with a rug in living quarters that had been dusted with parathion four months previously when the family went back north after the farming season. When the family returned, they swept up the insecticide but neglected to clean the rug.

Residential use and indiscriminate agricultural use of this pesticide is prohibited by law but enforcement is difficult. More educational effort is needed to instruct migrants in the proper use of pesticides and the prevention of infestations through proper house cleaning and garbage handling practices.

c. Recreational facilities:

Recreational facilities as such are rare in labor camps. The dining room of most camps is generally equipped with a juke box and or a pool table and doubles as a recreation room during evening hours. Recreation in these cases usually consists of playing pool, cards, games, etc. Migrants seldom have time or wish to participate in outdoor sports, though some of the larger camps provide baseball fields and other forms of physical recreation. Fishing is very popular with migrants. Numerous canals containing a variety of fish are found within walking distance of all labor camps. The majority of migrant families have television sets and most of the larger camps provide a television set in the recreation room.

The greatest need is for recreational facilities for children. There is a critical need for child care centers which, in addition to providing recreation for children, would allow other members of the family to work to supplement family income. Many children are kept out of school to care for younger members of the family while the mothers work. A large portion of damage to housing facilities is attributed to children who have nothing better to do.

d. By far the most difficult problem is the general cleanliness of sanitary facilities and premises of labor camps. While most camps now meet all physical requirements, including collection and disposal of garbage, it is hard to maintain an attractive environment due to the misuse of facilities and careless handling of garbage and trash by the occupants. Broken glass from carelessly discarded wine and beer bottles and from broken windows not only contributes to the unsightliness of camp premises, but also poses a safety hazard to the occupants, especially small children who seldom wear shoes. One of the answers seems to be a combination of supervision and regimentation of the camps' occupants. Most growers are reluctant to use a "get tough" policy for fear of losing their labor force. Others hire enough maintenance personnel for clean-up, but too large a number choose to try to ignore the problem with resulting deterioration in camp sanitation.

In the past, sanitarians were stressing structural improvements and it was hard to get camp operators to concentrate on cleanliness when they were facing large expenditures for physical repairs and also the type facilities provided were not conductive to proper maintenance. Now that most camps meet physical standards, the sanitarians are devoting more time toward improving camp maintenance. It is found that frequent visits are necessary in most cases to maintain level of camp cleanliness.

III. Work locations.

This season, more effort was devoted to the provision of sanitary facilities for workers at field locations. Although only 124 of the estimated 500 field locations were visited, conferences were held with some of the key growers representing all types of crops in order to establish minimum standards for drinking water, handwashing facilities, and toilets. A memorandum, a copy of which is included in this report, was prepared and distributed to growers this season with the understanding that real efforts toward compliance will be expected.

The most difficult problem lies with the provision of acceptable toilets. Portable chemical toilets, provided and serviced by a contractor, are the best solution. However, in addition to the high cost, most of the locations are not readily accessible for servicing. Stake tomato growers, whose crop is permanent in nature, found that permanently located privies with shallow pits were feasible and paid for themselves in time saved from farm workers leaving the field when toilets were not provided. With short duration crops, such as beans and corn, where harvesting is completed in one day in a particular field, resistance has been encountered in providing any kind of toilet facilities. Sled-type toilets, kept abreast of the harvesting area, are used by some growers and most of the celery growers are installing chemical toilets on the harvesting machines.

Another major problem is in providing enough water for handwashing. Very few growers are providing handwashing facilities of any kind. Efforts are being made to get them to provide portable tanks of water in conjunction with the field toilets.

Many crops are now harvested by contractors and it is difficult to fix the responsibility for providing sanitary facilities. In all cases, the cooperation of the workers is needed to get them to express a desire for proper sanitary facilities. The lack of demand on the part of field workers and crew leaders has retarded progress in obtaining these needed improvements.

IV. The major effort in health education on the part of the environmental health staff consisted of instructions and advice to occupants and the supervisory staff of housing facilities in sanitation practices and the care of facilities and premises. The total of these health education visits by type is shown in the accompanying table. Efforts were coordinated with the project health educator where problem areas existed in labor camps and rooming houses.

Results are very slow in showing up from this program activity largely due to the failure of migrants and housing supervisors to grasp the relationship of a proper environment to personal health.

Future plans include increasing the use of films and slides at clinic sessions, schools, and housing locations. This visual aid material will include elementary bacteriology and the significance of poor sanitation practices in the transmission of disease. Project personnel have accumulated numerous color slides showing actual conditions, good and bad, existing in local housing facilities. These slides are valuable in demonstrating health techniques as well as orientation for groups interested in migrant health activities.

VISITS RELATED TO HEALTH EDUCATION BY TYPE

Campsite	106
Shelter	395
Heating and Lighting	55
Fire Protection	85
Food Service	497
Water Supply	182
Sanitary Facilities	571
Plumbing	136
Sewage Disposal	256
Garbage and Trash	358
Pest Control	191
General	425

V. General Appraisal of Sanitation Program:

A. The sanitation program progressed as planned although one senior sanitarian position in the "Glades" area remained vacant throughout the season, hampering efforts in that area. All camps were inspected during the year. Frequent visits were made to camps where maintenance was a continual problem. Less emphasis was placed on the camps for off-shore labor since these are kept in relatively good condition due to the contract involved which makes proper housing mandatory. As shown in Table "B", a total of 2,578 inspections were made to camps and other housing locations with 1,397 of these to labor camps.

Continued inspections were made of the rooming houses in the "Glades" area by the sanitation aide. The main purpose of these visits was to promote cleanliness of premises. This program was moderately successful as evidenced by the favorable comments of personnel of other agencies providing services to migrants and by the rooming house occupants. A critical problem yet to be solved involves the use of sleeping rooms by families who conduct their cooking operations without proper facilities. Due to the lack of family units and the fact that sleeping rooms are cheaper than apartments, it may take years to overcome this problem. The planned county-wide minimum housing code is not yet in effect. It is hoped that future enforcement of this program will solve many of the county's housing problems such as the rooming house problem mentioned above. However, a program is now under way, in cooperation with the county building and zoning department, to condemn, and require the demolition of, some of the old substandard structures.

A major objective is in providing environmental health educational services to migrants. As stated in number IV of the Sanitation Section, little success can be claimed for this program, although much effort has been applied.

Objectives are being met in varying degrees; however, no let-up can be forseen in any direction.

B. A variety of methods are used to obtain the correction of defects although none are really successful unless all parties concerned become convinced that improvements are necessary. This seems to indicate that educational effort is the real tool involved and the other methods are used to get the attention of those concerned. Legal action was taken against four camps' operators this year, resulting in the closure of two camps and temporary compliance in the other two cases. Further legal action may be necessary to convince two operators that permanent improvements are mandatory.

Generally a simple conference is all that is required to obtain the correction of defects except for the maintenance of premises and sanitary facilities which is a never-ending problem, especially in dormitory type housing where central facilities are used. As indicated elsewhere in this report, frequent visits are needed in these cases.

VI. No special changes are indicated in future planning based on this year's experience. Efforts are being made to fill the two vacant senior sanitarian's positions. One of these positions was vacant throughout the season and the other was vacated in April of 1968, due to the retirement of the "Glades" area sanitarian who had been with the project since 1963. An experienced sanitarian has applied for this position and is expected to report for duty in July of this year. In order to provide coverage of the "Glades" area, sanitarians working out of the Hillville area office will alternate in providing sanitation services in this area which involves round trip travel of approximately 100 miles. It has been very difficult to find a sanitarian who will live in the "Glades" area, as it is rural in nature and lacks many of the conveniences found in the large coastal cities.

MEMORANDUM

TO: Food Crop Growers and Employers of Workers Engaged in the Growing and Harvesting of Food Crops

FROM: Division of Environmental Health, Palm Beach County Health Dept.

SUBJECT: Field Sanitation

The provision of sanitary facilities at crop locations, including safe drinking water, handwashing facilities and toilet facilities is recognized as being essential in order to protect the health of the consumers of the crops as well as the health of the workers.

It is a legal and moral responsibility of Food Crop Growers and other employers of workers engaged in food crop growing to provide such sanitary facilities, as will safeguard the sanitary quality of the food grown and preserve the health and dignity of the field workers.

The following is offered as a guideline for the provision of sanitary facilities at crop locations:

(1) Drinking water shall be from an approved source and shall be stroed in proper closed containers equipped with a spigot.

(2) Handwashing facilities shall be such as to afford an opportunity

to wash hands in clean water using soap or other suitable cleansing agent and to dispose of used wash water without nuisance or contamination of food crop.

(3) Toilet facilities shall provide privacy and shall be so designed as to keep human excreta from contaminating the crop and to keep flies away from the excreta. Toilet paper shall be provided. Toilet facilities shall be maintained in a clean and sanitary condition.

(4) One toilet and one handwashing facility should be provided for each 40 employees and at convenient locations. Locations within a five-minute walk of place of work would be considered convenient.

In the event problems are encountered in providing any of these facilities or for any questions regarding this memorandum, please contact one of the following offices:

Hillville Rural Health Center
Route #3, Box 8541
Lake Worth, Florida 33460

Telephone: 732-5545

Belle Glade Health Center
Post Office Box 934
1024 N.W. Avenue "D"
Belle Glade, Florida 33430

Telephone: 996-5219

HEALTH EDUCATION

I. General description of health education service.

A. Staff

1. Professional health educator.

The health educator II joined the project December 11, 1967, filling the vacancy created by the resignation of the previous health educator, and is the only health educator on the health department staff. The educator spent a great deal of time getting acquainted with and being oriented to the community, the organization of the Palm Beach County Health Department, the agricultural migrant, and his specific health problems, and building a working relationship with staff members.

B. Specific objectives and duties.

1. To stress the importance of good health habits and personal hygiene through educational process.

2. To strive to create an awareness among the migrants of their responsibility in proper use and care of sanitary facilities.

3. To continue to define the health education needs of migrants and, based on these needs, to provide a program of health education for the improvement of personal and environmental health of migrants.

4. To inform the general public of the health needs and services for domestic agricultural migrants.

5. Duties: Establish working relations and maintain liaison with various community groups and schools; prepares and selects pamphlets and other educational materials for distribution to migrants. Conducts individual and group conferences with migrants. Prepares weekly and monthly annual reports as required. Cooperates with associations, schools, and voluntary health agencies in programs for migrants.

C. Relationships with other project staff, migrants, growers, and others.

The health educator assists the other disciplines on the project in matters pertaining to public health education, especially in sanitation services. The sanitarians and public health nurses also participate in health education activities as a part of their daily activities.

The health educator initiated conferences with growers, camp operators, and crew leaders in an attempt to change their individual attitudes about providing health services for the migrant worker. Working relationships were established with various groups and individuals. The health educator served with planning, advisory, and actions groups in providing educational services to migrants. Included are:

1. The American Friends Society.
2. Baptist Aid to Migrants.
3. Human Resources Development Committee.
4. Manpower Development Training Association.
5. Community Action Fund, Inc., Migrant Project Staff.
6. Christian Ministry to Migrants.
7. Adult Education to Migrants.
8. Everglades Progressive Citizens, Inc.

D. Consultation and assistance obtained from outside project - type and source.

1. Health Department personnel.

    a. Project Director: Overall guidance on project matters.

    b. Assistant Health Officer: Guidelines on communicable disease control.

    c. Health Program Analyst: Provides assistance and consultation on:

        (1) Planning educational programs for migrants,
        (2) Orientation on all health department programs,
        (3) Other health department special projects.

    d. Health Department Librarian: Assisted in preparing and selection of pamphlets and audio-visual aids.

    e. MIC Nutritionist: On general nutritional concepts and diets.

    f. MIC Medical Social Worker: Social service programs available to migrants.

g. County Welfare Worker: Surplus commodities and welfare benefits to migrants.

E. Consultation needed.

Since the health educator is new to the Migrant Health Project and is not public health oriented, continual consultation is needed from all other disciplines within the project, as well as other professional staff members from the health department. Specific consultation is needed from the statewide Migrant Project health educator and from the Division of Health Education of the Florida State Board of Health.

II. Description of services provided to migrants, to other project staff, to growers, and to other community groups.

Talks were given and discussions held with various migrant groups. Audio-visual aids were used to illustrate and explain the main subject matter. Example:

1. Meetings were held and discussions conducted on the improvement of sanitary conditions for migrants, at the office of the Everglades Progressive Citizens, Inc., Belle Glade, Florida.

2. Films were shown for the purpose of actual demonstration as to "how and why" one should observe basic sanitation. "A Healthier Place to Live," "Keep Clean - Stay Well," and "Safe Food" were films used. Group discussions followed these programs.

The health educator and members of the project staff are encouraging migrants to:

1. Attend migrant health clinics,

2. Eat balanced diets, especially some of the crops they harvest,

3. Emphasized school attendance for both children and adults,

4. Special emphasis was made on vocational training and adult education.

(Refer to pictures on Plate C)

The health educator assisted in developing in-service training for crew leaders, with the American Friends Society. He took part in an adult education class for migrants in which he taught health education to adult migrants at Marymount College and at the public schools during the summer. At least 250 persons attended the health education classes.

The health educator assisted sanitarians in environmental health programs for migrants. No specific programs with growers were possible this year due to the resignation of the health educator in the summer.

A. Kinds of problems brought out in individual or family counseling, group counseling, group education.

1. Problems brought out in counseling and group education are: personal hygiene, medical care, legal aid, social security, and venereal disease.

2. Group counseling covering problems in environmental health and housing are: proper use of toilet, proper garbage and trash handling, and maintenance of individual housing unit.

3. Group education was conducted at the Hillville health clinic and covered problems in family planning and maternity and infant care.

B. Kinds of activities handled at request of project director, nurses, etc.

1. The health educator devoted time to helping other staff members in screening printed materials and audio-visual aids for use in individual and group instruction with migrants.

2. Assisted the nurses and sanitarians in preparation of slides for use in orientation and educational programs.

3. Served as liaison and resource person in the contact investigation of migrants in intimate contact with active tuberculosis cases, to lessen the communication barrier.

4. Assigned to assist in the random sampling of the migrant population in the "Glades" area in order to allay the fear among migrants that the random sampling was actually a device to obtain information on the number of migrants eligible for the draft.

C. Kinds of problems discussed with growers and other community groups and outcome.

1. Maintenance and misuse of facilities.

   Set up educational program in some larger camps to show and demonstrate the proper use of basic sanitary facilities.

2. Meetings were held with various community officials on the improvement of housing and sanitary conditions for migrants, and the problems of hunger and the misuse of surplus foods among migrants.

III. Appraisal of effectiveness of educational effort.

The willingness and eagerness of various organizations providing services to migrants in requesting the assistance of project staff and the health educator in the organization of programs of orientation, adult education, and social service is an important factor in developing educational programs. Other factors are:

1. Cooperation between migrant project staff and department personnel.

2. Development of the skills and knowledge in the art of communication between the migrants and staff, through an interpreter and Spanish speaking project staff member.

3. Ability to involve camp occupants in the identification and solution of health problems, as they see them.

4. Planning and develop with migrants of constructive and effective program in sanitation and personal hygiene.

5. The use of audio-visual material with Spanish dialogue is helpful.

A. Kinds of problems overcome, and in what ways.

1. The language barrier has been overcome by having bilingual physicians, clinic and sanitation aides.

2. The communication gap has been reduced by the health educator being of the same ethnic group as the majority of migrants.

3. The Hillville Health Clinic has been remodeled so that group education sessions can be held.

4. A Wilson movie mover was obtained and gives the flexibility of showing films outdoors as well as inside the clinic building during clinic sessions.

B. Kinds of problems which hindered effectiveness of program and remain to be solved.

1. The tendency of migrants to retain their colloquial methods in combating illness - example:

   The use of spiderwebs to heal sores caused by cut or infection.

2. Migrants' conception of the causes of illness and infection - example:

   That gonorrhea is caused by lifting heavy objects.

3. The large number of migrants that come into the area each year, making it possible to reach only a small percentage.

4. The widespread locations where migrants live.

5. The long hours of employment in the fields, causing physical fatigue and late return to migrant quarters, preclude acceptance of educational programs on scheduled basis.

6. The lack of adequate, low-cost mass transportation to bring migrants to a conveniently located site for educational programs.

7. Attractions outside camp area, such as bar, taverns, etc.

IV. Specific plans for future objectives, procedures.

The health educator will continue to give assistance to:

A. The American Friends Society training program for crew leaders and others.

B. Florida Atlantic University in their anthropological study of migrants.

C. Natural Educational Associates for Research and Development, Inc., for educating adult migrants.

D. To develop health education programs to meet the needs of migrants in cooperation with the project staff, and to evaluate the educational material being developed by Florida Atlantic University and other research facilities that are located in the county.

E. Attempt to involve more migrants in educational programs by taking the programs to the migrants.

Below is a listing of health education activities:

TYPE OF ACTIVITY	NO.	AVERAGE NUMBER OF PERSONS/SESSIONS
Meetings attended as spectator	8	22
Meetings attended as participant	15	12
Talks made	2	35
Programs using audio-visual aids	8	15-50
Exhibits	0	0
Individual counseling sessions	232	1
Group counseling sessions	29	3- 5
Health education teaching sessions	5	50
News articles	3	0

POLK COUNTY HEALTH DEPARTMENT

William F. Hill, Jr., M. D., Director

Area of County:	1,861 square miles
Resident Population:	212,000
Migrant Health Project Staff:	2 Public Health Nurses 1 Senior Sanitarian

PRETEST DRAFT - 1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT
For May 1, 1967 through April 30, 1968
Date submitted May 12, 1968

PART I - GENERAL PROJECT INFORMATION

1. Project Title

A program to develop a statewide program of health services for migrant farm workers and their dependents in Florida.

2. Grant Number (use number shown on approved application)

MG-18E (68)

3. Name and Address of Applicant Organization

Polk County Health Department
229 Avenue D, N.W., P.O. Box 1480
Winter Haven, Florida 33880

4. Project Director

William F. Hill, Jr., M.D.
Polk County Health Department
P.O. Box 1480
Winter Haven, Florida 33880

5. Population Data - Number of Migrants (workers & dependents) for Polk County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	3000	NA	NA
Under 1 year			
1 - 4 years			
5 - 14 years			
15 - 44 years			
45 - 64 years			
65 and older			
2. In-migrants			
Total	3300	NA	NA
Under 1 year			
1 - 4 years			
5 - 14 years			
15 - 44 years			
45 - 64 years			
65 and older			
Workers Only	See School Statistics		

b. Number of migrants by month:

Month	Total	Month	Total
Jan.	6300	Jul.	
Feb.	6300	Aug.	
Mar.	5500	Sep.	
Apr.	5300	Oct.	1500
May		Nov.	2400
June		Dec.	4200

c. Average stay of migrants in county:
Out-migrants: 36-40 weeks
from Sept (mo.) through May (mo.)
In-Migrants: 30 weeks
from Nov (mo.) through May (mo.)

d. Source of information and/or basis of estimates:
Florida Employment Service
Farm Labor Division
See Chart

6. Housing accommodations for Polk County:

a. Camps

Maximum Capacity	Number	Occupancy (peak)
Less than 10 persons	0	
10 - 25 persons	3	54
26 - 50 persons	2	72
51 - 100 persons	6	437
More than 100 persons	5	1,288

b. Other housing accommodations

Type	Number	Occupancy (peak)
Farms		
Other locations	14	745

c. Append map showing location of camps, roads, clinics, and other places important to project.

PRETEST DRAFT - 1967

Project No. MG - 18E (68)
Date submitted May 12, 1968
Polk County

PART II - MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services: See attached explanation

Age	Number of patients			Number of Visits
	Total	Male	Female	
Total				
Under 1 year				
1 - 4 years				
5 - 14 years				
15 - 44 years				
45 - 64 years				
65 and older				

2. Patients hospitalized: Not available

Age	Number of patients			Hosp. Days
	Total	Male	Female	
Total				
Under 1 year				
1 - 4 years				
5 - 14 years				
15 - 44 years				
45 - 64 years				
65 and older				

3. Patients receiving dental services:

Item	Total	Under 15	15 and Older
a. Number of migrants examined: total	75	33	42
Number of decayed, missing, filled teeth	43	43	0
Average DMF per person			
b. Individuals requiring services: total			
Cases completed	9	9	0
Cases partially completed	26	24	2
Cases not started			
c. Services provided: total			
Preventive			
Corrective	43	43	0
Extraction	26	24	2
Other			
d. Patient visits: total	46	44	2

4. Immunizations provided:

Type	Incomplete series	Completed immunizations - by age					Boosters, revaccinations
		Total	Under 1 year	1 - 4	5 - 14	15 and older	
All types		702	330	167	50		155
Smallpox		67	20	16	8		23
Diptheria		178	77	38	18		45
Pertussis		134	62	40	8		24
Tetanus		179	78	41	15		45
Polio		119	73	28			18
Typhoid		0	0	0	0		0
Measles		25	20	4	1		0
Other (specify)							

POLK COUNTY

5. Medical conditions found by physicians among outpatients, by age of patient:

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
I	Infective and parasitic dis.	84	1	12	28	38	5	
	Tuberculosis	18		1	4	8	5	
	Venereal Disease	28				28		
	Measles	0						
	Infestation with worms	29		9	18	2		
	Dermatophytosis & other infections of skin	0						
	Other	9	1	2	6			
II	Neoplasms	2				2		
	Malignant	0						
	Benign & unspecified	2				2		
III	Allergic, endocrine, metabolic, and nutritional dis.	3	1	1			1	
	Diabetes	1					1	
	Malnutrition	2	1	1				
	Other	0						
IV	Dis. of blood and blood-forming organs	0						
	Anemias	0						
	Other	0						
V	Mental, psychoneurotic and personality disorders	2				2		
VI	Dis. of nervous system and sense organs	12	1	5	3	2	1	
	Cerebro-vascular disease (stroke)	0						
	Eye Diseases	4		2	1	1		
	Dis. ear and mastoid pro.	6		2	2	1	1	
	Other dis. of nervous system	2	1	1				
VII	Dis. of circulatory system	7			3	3	1	
	Rheumatic fever	2			2			
	Diseases of the heart	1			1			
	Hypertension & other dis. circulatory system	4				3	1	
VIII	Dis. of respiratory system	55	26	18	6	5		
	Upper respiratory	55	26	18	6	5		
	Influenza and pneumonia	0						
	Bronchitis	0						
	Other	0						

5. Medical conditions found by physicians among outpatients, by age of patient (cont'd.):

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
IX	Digestive system diseases	68	13	5	44	5	1	
	Teeth and supporting structures	48		1	44	3		
	Gastroenteritis, colitis	19	13	3		2	1	
	Other	1		1				
X	Dis. of genito-urinary system	18	1	1	7	9		
	Urinary system diseases	9	1	1	5	2		
	Genital system diseases	9			2	7		
XI	Deliveries and complications of pregnancy	4				4		
	Complications of pregnancy	4				4		
	Deliveries	0						
	Compli. of puerperium	0						
XII	Skin diseases	28	8	8	7	5		
	Impetigo	20	7	5	5	3		
	Other	8	1	3	2	2		
XIII	Dis. of bones and organs of movement	7	1		3	1	2	
XIV	Congenital malformations	4	1	1	2			
XV	Dis. of early infancy	0						
XVI	Symptoms, ill-defined cond.	0						
XVII	Accidents, poisonings, violence	3		2		1		
	TOTAL OF CATEGORIES I-XVII	297	53	53	103	77	11	
SUPP	Special conditions, examinations, w/o sickness: total	753	151	142	140	320		
	Prenatal, postnatal care	321			8	313		
	Physical examinations	142	78	21	43			
	Immunizations	290	73	121	89	7		
	Surgical or medical after-care, follow-up	245	9	30	40	138	28	
	Fitting prosthetic devices	0						
	Other: Family Planning	199				199		

PRETEST DRAFT - 1967

Project No. MG - 18E (68)

Date submitted May 12, 1968

POLK COUNTY

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number	Services provided:	Number
a. Visits to homes	1450	f. Health supervision, counselling, teaching, demonstrating care in homes	1695
b. Total households served	1147	g. "Sick call" (nursing clinics)	
c. Visits to schools, day care centers: total	800	h. Referrals for medical or dental care: total	NA
d. Migrants presenting health record on request (PHS 3652)	363	Within area: total	NA
		Number completed	NA
e. Migrants given health record	428	Out of area: total	NA
		Number completed	NA
		i. Other (specify) See Outpatient Chart	

2. Sanitation services

Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	16	14	97	35	175	32	28	1186
Urban or other locations	14	0	149	0	745	4	0	240

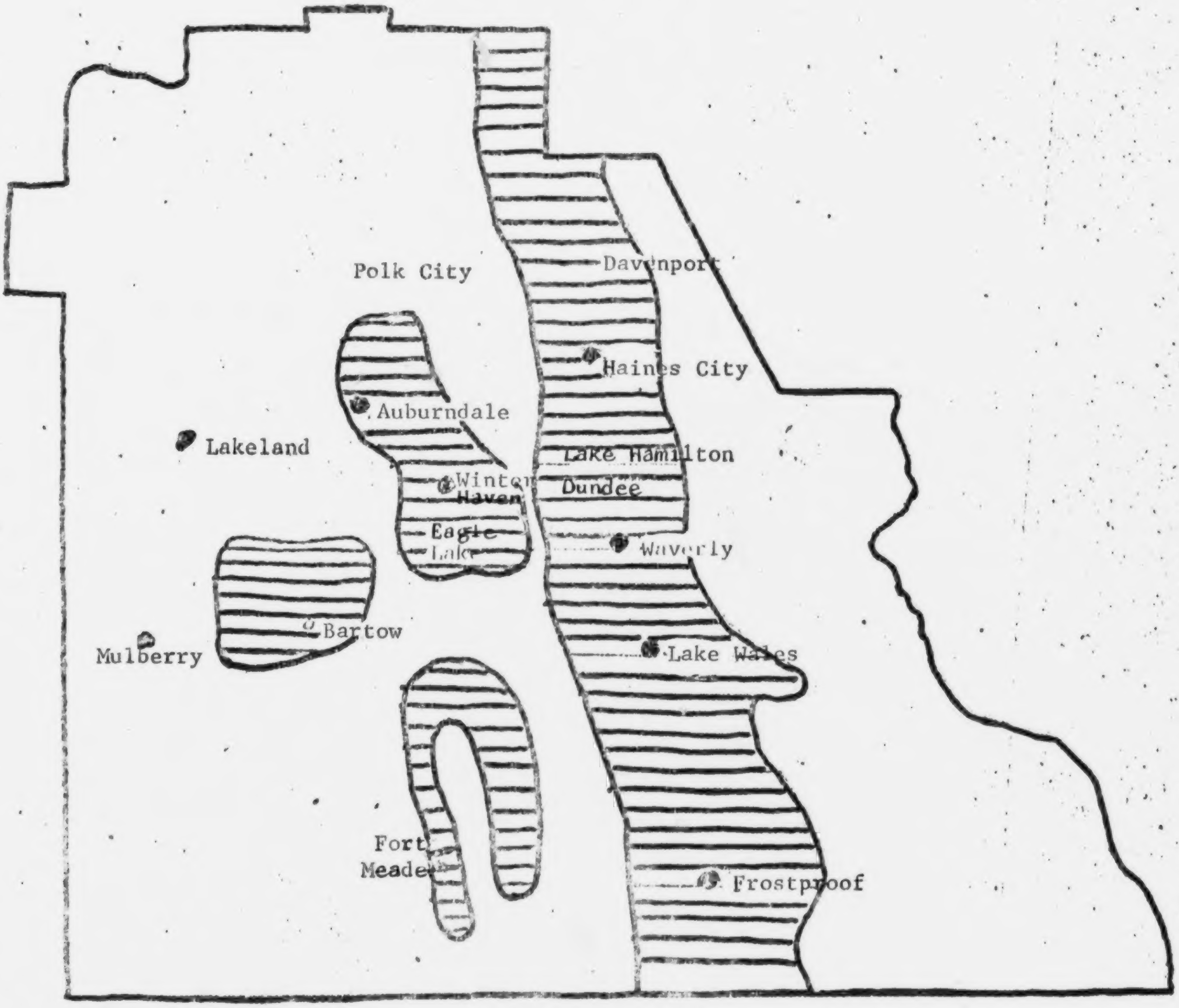
Table B. Inspection of living and working environment of migrants

	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	31	46	61	61
b. Sewage	78	72	63	58
c. Garbage and refuse	57	134	287	166
d. Housing	293	437	2,622	147
e. Safety	293	437	1,311	58
f. Food handling	83	418	1,254	836
g. Insects and rodents	56	61	40	23
h. Recreational facilities	17	17	4	4
Working environment				
a. Water	35	58	106	72
b. Toilet facilities	35	58	232	65
c. Other Food Handling	35	58	290	131

* Locations - camps or other locations where migrants work or are housed

POLK COUNTY

Migrant families live and work in the areas of the county indicated by the horizontal lines.


Polk City
Davenport
Haines City
Auburndale
Lakeland
Lake Hamilton
Winter Haven
Dundee
Eagle Lake
Waverly
Bartow
Mulberry
Lake Wales
Fort Meade
Frostproof

● Health Department Clinics

▤ Citrus Growing Areas

Scale: 1" = approximately 10 miles

EMPLOYMENT IN CITRUS CANNING PLANTS AND PACKING HOUSES

Polk County

Migratory Worker Study

	1964-65	1965-66	1966-67	1967-68
AUGUST	2,203	2,561	2,682	2,803
SEPTEMBER	2,414	2,752	2,717	3,361
OCTOBER	4,822	5,898	5,380	6,255
NOVEMBER	9,342	9,920	10,716	10,201
DECEMBER	10,408	10,964	12,027	11,405
JANUARY	10,913	11,499	12,510	10,863
FEBRUARY	10,255	11,228	12,188	10,460
MARCH	9,633	10,827	11,802	10,047
APRIL	7,833	7,706	9,904	
MAY	5,920	6,708	8,585	
JUNE	3,055	4,297	5,748	
JULY	2,258	2,714	3,938	
AUGUST	2,561	2,682	2,803	
AVERAGE	6,600	7,300	8,400	

STATE DEPARTMENT OF EDUCATION

DATE August 21, 1967

COUNTY Polk

RETURN TO: John H. Wheeler, Coordinator, Title I
Office of Federal-State Relations
State Department of Education
Tallahassee, Florida 32304

Migratory pupils aged 5 to 17, inclusive (1966-67 school term):

	Residing in the State Full Time		Residing in the State Part Time	
	(1) Number	(2) Aggregate Days Membership (ADM)	(3) Number	(4) Aggregate Days Membership (ADM)
Pre-School	800*		550*	
Kindergarten	300*		400*	
Grades 1- 6	1,523	220,590	2,427	289,899
Grades 7-12	536	66,889	650	80,486
TOTALS	3,159	287,479	4,027	370,385

To determine the number of full time equivalents, please compute as follows:

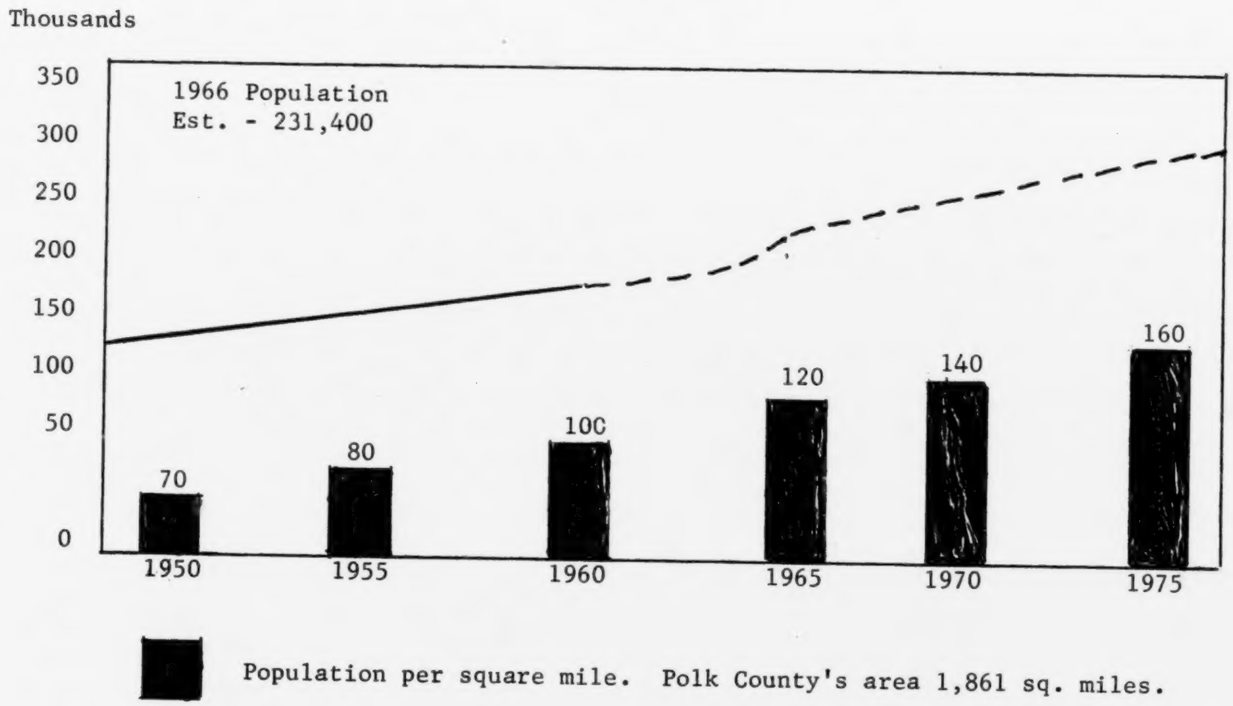
(1) Total Column 2 ____________ plus Total Column 4 = 657,864 (Total ADM)

(2) Total ADM / 180 = 3,655 (F.T.E.)

Superintendent
(or person filing report)

* Figures based on estimates made by principals.

POPULATION GAINS
POLK COUNTY
1950 - 1975



■ Population per square mile. Polk County's area 1,861 sq. miles.

Year	Population	Annual Gain
1950	123,997 (Census)	3,733 - av. for 1940-50
1960	195,100 (Census)	7,260 - av. for 1950-60
1961	203,300	6,700
1962	207,600	4,300
1963	208,600	1,000
1964	210,800	2,200
1965	214,300	3,500
1966	231,400	17,100
1970	254,400 (Projected)	-----
1975	291,400 (Projected)	-----

SOURCE: Bureau of Economic and Business Research, University of Florida

K. W. RINGDAHL, Manager
Florida State Employment Service
515 East Lemon St. - Ph. 682-7116
Lakeland, Florida

Released by: G. M. SIMMONS, Manager
Florida St. Emp. Service
401 N.W. 5th St. - Ph. 294-3113
Winter Haven, Florida

SCHOOL CENTERS WHERE MIGRATORY PUPILS WERE ENROLLED

Lakeland Senior
Lakeland Junior
Central Avenue Elementary
John Cox Elementary
Medulla Elementary
Oscar Pope Elementary
Rochelle Jr.-Sr. High
Rochelle Elementary
Lincoln Avenue Elementary
Haines City Senior
Haines City Junior
Alta Vista Elementary
Central Elementary
Eastside Elementary
Davenport Elementary
Dundee Elementary
Oakland Jr.-Sr. High
Bethune Elementary
Myrtle Street Elementary
Winter Haven Senior
Denison Junior
Lake Alfred Junior
Brigham Elementary
Eagle Lake Elementary
Garner Elementary
Inwood Elementary
Lake Alfred Elementary
Lake Shipp Elementary
Snively Elementary
Wahneta Elementary
Jewett High
Jewett Primary
Jewett Elementary
Fruitland Park Elementary
Fort Meade Jr.-Sr. High
Lewis Elementary
Riverside Elementary
Anna Woodbury Elem.-Jr. High
Auburndale Senior
Auburndale Junior
Auburndale Central Elementary
Lena Vista Elementary
Caldwell Elementary
Bridgers Avenue Elementary
Bartow Senior
Bartow Junior
Bartow Elementary
Alturas Elementary
Highland City Elementary
Union Academy Elementary
Union Academy Jr.-Sr. High
Gibbons Street Elementary
West Bartow Elementary
Mulberry Jr.-Sr. High
Mulberry Elementary
Kathleen Senior
Kathleen Junior
Kathleen Elementary
Griffin Elementary
Jesse Keen Elementary
Winston Elementary
Padgett Elementary
Frostproof Jr.-Sr. High
Frostproof Elementary
Lake Wales Senior
Lake Wales Junior
Hillcrest Elementary
Polk Avenue Elementary
Spook Hill Elementary
Roosevelt Elem.-High
Janie Howard Wilson Elementary

POLK GENERAL HOSPITAL
AND CLINICS

October

General Practice	1331
Surgery	409
Pediatrics	391
Internal Medicine	98
Ob-Gyn	265

November

General Practice	1202
Surgery	315
Pediatrics	381
Internal Medicine	79
Ob-Gyn	167

December

General Practice	1089
Surgery	298
Pediatrics	324
Internal Medicine	47
Ob-Gyn	189

January

General Practice	1462
Surgery	281
Pediatrics	439
Internal Medicine	0
Ob-Gyn	195

February

General Practice	1300
Surgery	326
Pediatrics	491
Internal Medicine	6
Ob-Gyn	218

March

General Practice	1379
Surgery	332
Pediatrics	425
Internal Medicine	0
Ob-Gyn	212

MIGRANT REPORT

May 6, 1968

December, 1967

Family Units	Number in Family Seeking Help	Total in Household
28	93	110
Aided	Rejected	Total Registered in Social Services
15	7	930

January, 1968

Family Units	Number in Family Seeking Help	Total in Household
25	90	114
Aided	Rejected	Total Registered in Social Services
12	6	1,440

February, 1968

Family Units	Number in Family Seeking Help	Total in Household
50	106	190
Aided	Rejected	Total Registered in Social Services
22	9	1,410

March, 1968

Family Units	Number in Family Seeking Help	Total in Household
26	98	153
Aided	Rejected	Total Registered in Social Services
16	8	1,120

April, 1968

Family Units	Number in Family Seeking Help	Total in Household
24	54	62
Aided	Rejected	Total Registered in Social Services
16	6	1,168

This information is supplied by the Polk County Division of Welfare and Rehabilitation.

The total in household figures (Migrant) range from about 5¼% to about 14% of the total registered of all county clients. Using an average of 10% as applied to the medical services given in the Outpatient Department of the County Hospital, you have an estimate of medical services to migrants and their families.

FLORIDA STATE EMPLOYMENT SERVICE
FARM LABOR OFFICE
P. O. Box 447
Dundee, Florida

Date	Polk Highlands Hardee 223 Employment	Polk County	Non-Migs.	Local Fla. Migs.	Inter-State Migs.	Un-employment	TOTAL MIGRANTS
October 1, 1967	3,00	2,500	1,200	1,300	0	0	1,500
October 31, 1967	4,500	3,700	1,400	1,950	450	0	2,400
November 30, 1967	6,400	5,600	1,900	2,575	1,125	500	4,200
December 31, 1967	7,700	6,700	2,000	2,800	1,900	0	4,700
January 31, 1968	11,000	8,300	2,000	3,000	3,300	0	6,300
February 29, 1968	9,600	7,200	2,000	3,000	2,700	600	6,300
March 31, 1968	7,500	6,500	1,500	2,500	2,000	1,000	5,500
April 30, 1968	9,900	7,300	2,000	2,600	2,700	0	5,300

POLK COUNTY MIGRANT PROGRAM REPORT

GENERAL INFORMATION

May 1, 1967 to April 30, 1968

The objectives were and are to improve preventive and medical care services to agricultural migrant families, to improve and upgrade general sanitation and housing, and to coordinate and cooperate with community agencies in assisting with programs for the betterment of agricultural migrants and their families.

There has been a further increase in migrants of Spanish extraction and a few American Indian families. The predominant group is southern Negro. The in-migrants come from the South-Eastern states, Texas, and New York. Migration from Florida is predominantly to the Mid-Atlantic states for three to six weeks before moving on to the Eastern shore and New York state. This migration begins in June and is usually complete by early July. Migration may begin a little earlier this year due to a smaller crop yield and current dry weather. Fruit is souring on the tree because of the drought. There was a period of unemployment during February and March involving 600 and 1,000 workers respectively (see employment chart). The United States Department of Agriculture is predicting a small crop for next year and the current drought may reduce it further. A new farm-interest has 2,900 acres of corn under cultivation and are clearing enough additional acreage to total 7,200 acres. There is also some interest in farming the reclaimed phosphate mining areas. A small citrus crop and new farming interests make the labor market very fluid. I see a continued need for social and health services.

There are nine widely distributed health centers in Polk County (see map). One of these is sponsored in conjunction with a citrus cooperative. A schedule of clinics is attached. A full range of public health services, including certain medical care services, is available to the agricultural migrant and his family. All resident migrants have access to Polk General Hospital (County owned and operated) for total medical care services and non-resident migrants are cared for on an emergency basis. Services available in our general clinics are physican examinations, diagnosis, treatment, immunizations, prenatal and postnatal, pediatric, family planning, home nursing, and dental services. Referral services for mental health, orthopedics, cancer, heart, rehabilitation, blind, deaf, and mental retardation are available. Glaucoma detection is a special service. Community agencies such as the Lions Club with special health projects cooperate in serving migrants. We have added five evening family planning clinics using specialists from private practice. A limited dental program for prenatal patients in private dentists' offices is now available. Routine pap smears are done on family planning and V.D. patients. We are cooperating in a grant request to do pap smears on all inpatients at Polk General Hospital. The evening clinics should act as a rallying point for other services.

We have started a new team approach using Home Health Aides in clinics and home visiting, as well as home nursing care. We now have 13 such aides. We plan to continue exploration in the use of auxiliary personnel to improve our delivery of services.

Hospital financing remains a serious problem. I do not believe many people needing hospitalization are denied this service, but they probably must be more acutely in need before admission. Lack of an attractive reimbursement package in an ever spiraling cost era is a deterrent to hospitals which might participate. Local residency requirements tend to hamper the county hospital until the emergency state is reached.

Two trained clinic aides provide eye screening in all the county schools under the direction of a local ophthalmologist. Notices are sent to the parents for care as needed. The Lions Club sight conservation program helps with glasses.

Several of the citrus growers are cooperating in our intensified T.B. and V.D. detection programs. We have about 30 migrants on chemoprophylaxis for T.B. Several of the church groups and a civic club have transportation and clothing projects for migrants.

Polk County is one of the areas certified by the Florida State Board of Health for the required two month nurses orientation to public health. We have several new nurses from our own staff and two out-of-county nurses participating. Migrant health problems is one of the topics discussed.

I feel we are making continuing progress toward meeting our objectives as evidenced by evening family planning clinics, use of auxiliary personnel, prenatal dental care, cancer detection, TB chemoprophylaxis, and improved cooperation with the county hospital and community agencies. Problems are the same as with any service given to the lower socioeconomic group - why don't they work harder, spend wisely, plan for the future. The community does not recognize their value in the overall economic scale. Problems of transportation, much time invested per accomplishment, superstitions, and different values are ever present.

The last Review Committee noted no strengths. If we have any strengths, it lies in a built-in desire to do better.

Plans for the future include strengthening our prenatal and family planning coordination through increasing nursing time, modification of our doctor/nurse time allotment in prenatal care, and expanding our screening for asymptomatic bacteruria in pregnancy.

MIGRANT SERVICE REPORT - NURSING

Public health nursing service to migrants is given as a part of that provided for the general population. This includes health screening with referral or treatment and follow-up; health supervision and education. The work is carried on in nine clinic facilities (see attached map), the homes of patients and in schools. Nurses are available for assistance in every office every day. A physician is available daily in the Lakeland and Winter Haven clinics, twice or three times weekly in Haines City, Lake Wales and Bartow, and once weekly in the other four units. Ninety-five per cent of the population lives within five miles of a clinic facility.

The nursing staff is comprised of 43 nurses and 13 aides. Thirty-seven of the nurses, including two employed with migrant funds, are assigned to a geographical district and are responsible for all nursing service given within that district; including care of the sick at home and school nursing. Six nurses are assigned to supervisory or administrative duties. The 13 aides assist with patients in clinics and in homes. Red Cross volunteers are used to assist with traffic and clerical tasks in clinics and provide transportation for a limited number of patients.
During the past year, migrants, as a high-risk group, have been given a high priority

for nursing time, particularly in the maternal, child health, birth control, and tuberculosis programs. Five evening clinics have been organized to make birth control education, services and material more easily available to them. These clinics have been poorly attended. They may be better utilized if more nursing or aide time were available to advertise them. Considerable time has been spent in the past months to find ways of reaching citrus picking crews for the purpose of giving them tuberculin skin tests with the intent of offering prophylactic chemotherapy to all positive reactors. We have agreements for full cooperation with four citrus processors at the present time. These four firms employ approximately 2,000 pickers. The first picking group will be skin tested the week of May 20.

Several problems have been encountered in contacting pickers:

(1) Crews picking for one processor do not go to any given location for any purpose in the course of a week. The person giving the test would therefore have to ride the bus or truck. Male aides may be used for this purpose if the Tine testing material could be purchased and if medication could be prescribed on the basis of the result of this test.

(2) Obtaining x-rays on these persons and being able to find them several weeks later presents still another problem.

(3) There is no written material designed for persons with limited reading ability to reinforce verbal instruction about prophylactic chemotherapy.

During the coming year we expect to upgrade our entire maternity service. The problem unique to migrants in this program will continue to be provision for the cost of delivery. This deficiency will tend to nullify other improvements we will be able to accomplish.

There are no services offered to migrants in general by Public Health Nursing that are not offered to resident patients with the same needs. The difference lies in the priority for nursing time given to them and in the amount of medical treatment given. Records of migrant patients are marked with a large red "M" which identifies them as high-risk patients. Referrals within the county are accomplished by written or telephoned contact or by transfer of copies of records. Out-of-county referrals are made on the form devised by the Migrant Referral consultants for this purpose. Incomplete addresses and medical and nursing information make follow-up impractical or impossible for some patients. The underlying reason for this failure is that the migrant giving the information simply does not know the information required.

The public health nursing service of this county, as compared to that of other counties in the state, is considered to be among the best. We, intimately connected with it, are aware of several rather important weaknesses:

(1) There is not adequate administrative staff to give enough time to researching better and more efficient ways of getting the various tasks accomplished.

(2) Record management is far too time consuming and uninformative.

(3) The distribution of migrants in the county makes concentrated

and special efforts and methods impractical. Many migrants resent and resist being singled out as a special group.

(4) Nurses generally are concerned with the person involved and his needs without regard as to how he is classified by any other group. The very fact that a group can be set apart on the basis of how his services happen to be funded is repugnant to most nurses.

(5) The underlying and probably the greatest problem of working with migrants, as with all people in this economic group, is that they do not understand the necessity to plan for or prevent future needs.

While solutions to the first four problems could be found, with adequate highly motivated personnel, the solution to the last will probably elude several future generations of professional workers.

MIGRANT LABOR PROGRAM ANNUAL REPORT
SANITATION - 1968

Our primary objectives in the Migrant Health Program are to assist the migrant in the adjustments toward better community health, thereby helping him to become more stabilized in the roots of community living and increasing in him the responsibility to meet his own health needs.

The citrus industry in Polk County foresaw keen competition developing for the domestic labor supply and began to make plans to meet it. We began the season by certifying clearance orders in cooperation with the Florida State Employment Service. Through close cooperation with this and other agencies, an improvement in family type housing began to assert itself. Several labor camps were renovated from dormitories to family units and food service facilities were subcontracted to commercial catering organizations.

The sanitation staff consists of one full-time and three part-time sanitarians. Other groups consist of the local Ministerial Association, Florida State Employment Service, Migrant Labor Division, teacher groups, and local building and zoning departments.

Due to the nature of their nomadic existance, migrant workers have been unable to secure for themselves and their families decent living standards. Community attitudes toward migrants vary. The temporary presence of workers and families presents a host of complexities. In assisting the migrant toward a stabilized and healthful environment, we hope to instill some aspects of community pride, thus enabling him to become integrated into the fabric of community life.

The seasonal turnover in population poses obvious problems in trying to measure accomplishments of the sanitarian's health program. Experience indicates that migrants have much greater need of environmental health services than does the general public. Some specific environmental health needs are: garbage storage and disposal service; improvements in excreta disposal; insect and rodent control; improved housing (such as installation of kitchen sinks, improvement in private water supply, source and method of delivery). Table I, appended, summarizes work accomplished during the past season.

The sanitarians were requested to certify migrant housing to employment services'

POLK COUNTY HEALTH DEPARTMENT
Clinic Schedule

LOCATION	TYPE OF CLINIC	DAY	HOUR
Auburndale	X-ray & Health Card	Wed. (2nd. & 4th. full week)	9:00 - 11:30
	Immunization	Wed.	1:00 - 4:00
	General & Nurse Conf.	Thurs.	8:30 - 11:30
Bartow	X-ray & Health Card	Fri. (2nd. & 4th. full week)	9:00 - 11:30
	Immunization	Tues.	1:00 - 3:30
	Gen. Med.	Wed. (1,2,3,4th)	1:00 - 3:00
	Maternity Nurse Conf.	Thurs.	9:00 - 11:00
Frostproof	Immunizations & Nurse Conference	Tues.	1:30 - 4:00
	X-ray & Health Card	Wed. (2nd. full wk.)	1:30 - 3:30
	General Medical	Mon. (2nd. & 4th.)	9:30 - 11:30
	Dental Clinic	Tues. (each)	8:30 - 3:30
Haines City	General Clinic	Tues. (each)	8:00 - 12:00 N
	X-ray & Health Card	Thurs. (2nd. & 4th.)	8:00 - 11:30
	New Maternity	Wed. (each)	8:00 - 11:30
	Immunization	Wed.	1:00 - 3:30
	Well Baby	Tues. (p.m.)	9:00 - 3:30
Lake Wales	X-ray & Health Card	Tues. (2nd. & 4th. full week)	9:00 - 11:30
	General Medical	Wed. (each)	9:00 - 11:30
	Nurse Conference	Wed. (1st. & 3rd.)	9:00 - 11:30
	Immunization & Nurse Conference	Wed.	1:00 - 4:00
	Maternity (Dr. Hardman)	Thurs. (2nd. & 4th.)	1:00 - 3:00
Lakeland	14 x 17 X-rays	Mon.	8:00 - 9:30 3:00 - 4:00
	X-rays & Health Card	Mon.	1:30 - 4:00
	Maternity-Nurse Conf.	Tues.	8:30 - 11:00
	General Medical & Well Child	Tues.	1:00 - 4:00
	Maternity Medical	Wed.	8:30 - 11:00
	Immunization	Thurs.	10:00 - 12:00 N
	Immunization	Thurs.	1:00 - 4:00
	General Clinic	Fri.	10:00 - 12:00 N
	Chest Clinic	Fri.	9:00 - 11:30
	IUD Clinic	Wed. (1st. & 3rd.)	12:30 - 2:00
	Dental Clinic	Mon. & Thurs.	8:30 - 4:00
Mulberry	X-ray & Health Card	Wed. (4th.)	12:30 - 3:30
	Immunization & Nurse Conf.	Tues.	12:30 - 3:30
	General Medical	Fri. (2nd. & 4th.)	12:30 - 3:30

(Continued)

LOCATION	TYPE OF CLINIC	DAY	HOUR
Winter Haven	Dental Clinic	Wed. & Fri.	8:00 - 4:30
	Well Baby & Postpartum	Mon.	12:30 - 2:30
	Orthopedic (Dr. Jahn)Jan.	Tues. (1st.)	8:30
	(Clinics now held each month)		
	Immunization	Wed.	12:30 - 4:00
	Maternity (Dr. Keith)	Thurs.	8:00 - 9:30
	General Medical	Thurs.	12:30 - 2:30
	X-ray & Health Card	Tues.	1:30 - 4:00
	Glaucoma	Fri. (last in mo.)	9:00 - 1:00
Waverly	Immunization	Mon. (1st. & 3rd.)	
		First Mon.	2:00 - 4:00
		Third Mon.	2:00 - 7:00
	General Medical	Mon. (2nd. & 4th.)	1:00 - 3:00
C9	Winter Haven Night Clinic	Third Monday night	
	Bartow Night Clinic	Third Wednesday night	
	Lake Wales Night Clinic	Third Tuesday night	
	Lakeland Night Clinic	Third Wednesday night	
	Haines City Night Clinic	Third Tuesday night	

representatives in order to process clearance orders. Joint inspections of premises resulted in numerous corrections. We were also successful in locating additional migrant housing through close cooperation with school authorities.

This movement toward interagency cooperation continues to grow, as did interdenominational cooperation among church groups. Rummage sales were held for migrant workers. The churches themselves are undertaking a strong program to combat social rejection by inviting migrants to take part in regular services and social events. One grower provided free bus service to dormitory workers so that they might be with their families during Christmas. Just as the cooperation between church groups reached new highs, so did interagency cooperation.

All of Polk County's permitted labor camps have met the requirements outlined in the Florida State Sanitary Code. Plans are under way to convert some of the dormitory type housing into family units. Much of the individual housing continues to be sub-standard and none of it is licensed. We have begun a period of transition in migrant housing in the Hill section of Haines City. Through close cooperation with the local building department, a movement is now under way to condemn obsolete frame dwellings and obtain replacements using modern construction materials. (See photos, Table II, appended). The use of trucks and buses as housing units continues to present problems.

The fact that these units are highly mobile explains the complications. We have noted for the first time that some migrants are now purchasing homes in middle class neighborhoods. While the number if few, this trend bears watching.

There was varied reaction from the grower in relation to requirements outlined in the Sanitary Code of Florida, Chapter 170C-32. Sanitarians were available to discuss and offer recommendations regarding compliance with the above regulations. This need becomes more evident as one views the county map depicting migrant areas. Migrant housing is scattered in some of the most remote areas of the county.

In reviewing environmental health factors concerning the migrant, we are proud of the accomplishments obtained in promoting better health. The information listed on the forms; Table B under Part II. Nursing & Sanitation Services, reflects the total number of these items which are being coordinated through the program. A vast majority of family housing is served by an approved public water supply or private well. Sewage disposal ranges from extensive use of outdoor privy to community type flush toilet. Garbage disposal through storage and burning in open drums continues to be a problem. There is little, if any, refrigeration. Ice is purchased weekly and stored in antiquated containers for use throughout the week. The housefly is a constant menace due to poor food handling practices. Recreational facilities continue to be lacking. Children entertain themselves with discarded cans, bottles and imagination.

The working environment of the citrus worker is unique. He leaves for the grove at dawn and does not return until dusk. The water barrel is carried on the truck and is usually filled while the vehicle is being serviced. There is no provision made for food handling; each worker carries a sandwich or two prepared at his home or mess hall. Toilet facilities in groves is primitive. Mobile maneuverability makes it extremely difficult to obtain compliance with good public health practice.

Participating in a workshop for teacher orientation seemed to be a logical place to plan educational activities, and this is where we began our program. Our encouraging and aiding in the organization of food handling schools was very successful.

Visiting schools and discussing migrant children with guidance counselors also provided other professional people with a working knowledge of environmental health problems. Good public relations and newspaper publicity combined to achieve needed support of old and new programs. (See Table III)

Certainly of major importance is that an overall appraisal of the program for the year just completed emphasized growth and expansion of environmental health services. Considerable time was given to consultation with all interested personnel. Technical assistance to growers in planning housing and construction alleviated many field problems. We also assisted in providing the leadership in all phases of developing and extending health services to migrants.

We remain optimistic in our plans for the future. Considerable progress has been made - more systematic progress could be made if we could obtain the services of a sanitarian aide. A statistical analyses of reports and a continuous summary would point up strengths and weaknesses in our programs. Our cooperative relationship with other state and local agencies will be strengthened to expand the health services to all migrants.

HEALTH EDUCATION

I. General description of health education service

A. Staff

Staff members from the entire health department continued to participate in health education services to the migrants in Polk County. As the health educator serves the general program, services were limited; but because of the need for health education with the migrants, this staff member determined to provide as extensive a program as possible.

B. Specific objectives and duties

1. Provide migrants with information on available services.

2. Provide educational programs for migrant families or family members that improve their health and well-being.

3. Coordinate migrant educational activities with health department staff members.
4. Cooperate with other agencies, industries, and civic groups in assisting programs which serve migrants.

5. Become better informed about the unmet needs of migrants and the culture of the Texas-Mexicans as more families of this ethnic group worked in Polk County in this reporting period than in other years.

C. Relationships with others

The health educator worked with the health officer, clinic physician, nurses, and the sanitarians in planning specific projects for migrants. Coordination of work was also with school personnel, labor offices, industrial nurses, and other agencies.

D. Consultation and assistance received

POLK COUNTY - TABLE I.
SANITATION

	Admitted this mo. "X"	Admitted to date	Visits this mo.	Visits to date
Water				
1. Public Water Systems		2	2	4
2. Private Water Plants	7	36	12	46
3. Bottled Water Plants				
Sewage				
4. Public Sewerage System	3	6	5	10
5. Private Sewerage Systems				
6. New Specification Septic Tanks Installed	9	46	17	72
7. New Specification Privies Installed	2	6	2	6
Miscellaneous				
8. Garbage Disposal Systems		2	2	10
9. Subdivision Analysis	xxxxxxxx	xxxxxxxx		
10. Percolation and Soil Log Test	xxxxxxxx	xxxxxxxx	2	17
11. Pollution Survey	2	6	3	9
12. Bathing Areas Surveyed	1	5	2	8
13. Public Swimming Pools		3		9
14. Schools	8	21	22	39
15. Mobile Home Parks		16	2	23
16. Camps	2	19	10	43
17. Tourist Courts or Motels		2		2
18. Child Care Centers		13		18
19 Complaints Investigated	30	90	68	169
20. Nuisances Corrected	xxxxxxxx	xxxxxxxx	34	109
21. Plumbing		1		1
22. Rabies - Animal Bites	7	72	47	163
Protection of Food and Milk				
23. Eating and Drinking Establishments	1	98	79	305
24. Food Processing Plants	1	6	10	34
25. Abattoirs				
26. Shellfish and Crustacea				
27. Grocery and Meat Markets		49	21	113
28. Other Food Establishments				
29. Number Foodhandlers Trained	xxxxxxxx	xxxxxxxx		
30. Dairy Farms				
31. Milk and Milk Products Plants				
32. Cows Bangs Tested	xxxxxxxx	xxxxxxxx		
33. Cows Tuberculin Tested	xxxxxxxx	xxxxxxxx		
34. Dairy Farms under Mastitis Control Program	xxxxxxxx	xxxxxxxx		
Field Visits				
35. Private Premises	51	99	52	100
36. Public Premises	1	22	1	27

The health educator had the opportunity to attend a three-day migrant health state conference in November and the Eastern States regional conference in March. In addition, conferences were held with the state project coordinator, the state migrant health educator, and the regional nutritionist on the migrant program.

II. Services

A. The health educator showed slides and films on home sanitation, nutrition, poison prevention, dental health, the common cold, child care, and hookworm to migrant families in Haines City, Waverly, and Bartow. Discussions were led with the groups by the nurse or the health educator after the teaching films.

B. When the health educator met with the public school home economics teachers in a pre-school meeting, the needs of migrants were discussed. Some needs mentioned were the limited cooking facilities of some migrants, instruction on proper storage and preparation of donated foods, and the need for health instruction.

C. At a December program, which was planned by school personnel for teacher aides who are now working with migrant children, a public health nurse, a sanitarian, and the health educator spoke on the physical needs of migrant children.

D. The health educator served as a consultant to the Florida Migratory Child Compensatory Program in Winter Park, March 5, 6 and 7.

E. The health educator assisted the Polk County Medical Association's Auxiliary with the showing of the film, "Dance Little Children", (venereal disease education) to fourteen civic groups throughout the county from November through March. The auxiliary had purchased the film for this project. This activity is being reported as indirectly being of value to the migrant program. A workshop was also held for teachers who serve migrant schools on venereal disease education.

F. The health educator participated in a series of food handling and nutrition classes for school lunch workers who serve migrant school children.

G. The health educator assisted in planning programs for students in the special guided studies section of the local junior college.

H. The health educator showed health films to the children while their parents attended the evening screening clinic in Gordonville. An older migrant child assisted the projectionist with the benches and field crates which were used for seats at the outdoor movies. This was also thought to be an "attention attraction" for the parents, as some came to see what was going on. They said they heard the music. The project was a joint effort with the Polk County Christian Migrant Ministry.

I. A mimeographed form was developed in English and Spanish on available health services for distribution to migrants (copy attached). This was given to teacher aides, labor offices, gas filling stations, and crew leaders. It is hoped that this form can be printed next season, if funds are made avilable.

J. Planned a fifteen-hour work schedule for five sociology students from the junior college who were interested in migrants and local poverty conditions.

K. Ordered birth control literature and secured film strips on a permanent basis for use in the family planning clinics.

L. Spoke to twenty representatives of the New York State Department of Education on the health problems of local migrant children at Snively Elementary School on the request of the health officer. For many children, the health is good, but some of the problems mentioned were poor nutrition; poor dental health; skin problems, specifically impetigo and creeping eruption; and venereal diseases. The need for adequate referrals and communications between the states was emphasized.

M. Arranged for the regional state nutritionist to speak to the Polk County Nutrition Committee in March on the migrant program in Florida.

III. Kinds of problems overcome

A. Because of the limit of staff, the health educator attempted to reach as many leaders and key people in the community as possible so these persons could continue to provide health education to the migrants. In this way, the program would have a concentric approach.

B. The main problem is lack of staff, projection equipment, funds for printing posters and materials which are needed locally.

IV. Future objectives will be a continued effort to meet the health education needs of migrants and to assist with a county steering committee of organization, agencies, and individuals who are interested in helping the migrant families in Polk County.

V. Some comments of migrants which were of interest to the health educator:

> "There are two bunches of migrants. Those that want a good day's work and the ones that are trashy." "I like to work with my hands, this is my kind of work, what I know best. Why should it be a disgrace to do what I done? I like to work with the crops." "We don't need a bottle of pills, (vitamins) when we're still hungry." "I won't take the pills (birth control), it might make the baby turn out wrong." "Do you have to wash citrus fruit, like apples, before you eat it?" A citrus forman: "The owner of the grove picked up a field box of wine bottles in the grove after 20 did about five hours of picking." (Alcoholism is a health problem among some migrant workers.) A mother: "I would like to see a kindergarten program started here. This boy (large 5 year old) needs some learning."

SUMMARY - POLK COUNTY

The project this year has been a year of conversion in trying to tool-up for the new report forms. Peak employment was up but there was also a period of unemployment, due to a smaller crop yield. New agricultural interest is developing in corn with 2,900 acres cultivated and project acreage of 7,200. Reclaimed phosphate mines also figure in future possibilities. Health services rendered to migrants include physical examinations, diagnosis, treatment, prenatal and postnatal, family planning, home

TENTATIVE PROGRAM FOR THE WORKSHOP FOR MIGRANT ASSISTANT PERSONNEL
December 13, 14, 15, 1967

	WEDNESDAY	THURSDAY	FRIDAY
First Session 9:00 - 10:30 a.m.	Welcome-Charles E. Stolz Director of Supervisory Staff Services Workshop Presentation - Julian M. Shaw "Causes & Prevention of Failures" - Dwight Smith	"Teaching the Disadvantaged" - Barbara Hutson - Evelyn Powell - Earl Dodson - Frank Nelson, Moderator --------------------------- "The Migrant Child and The Exceptional School Program" - Mabel Wunderlich "Use of the Slossum Test" - Doris Sanders	"Math and the Migrant Child" - Jerry Gaa
Break 10:30 - 10:45 a.m.	-------------------------	---------BREAK---------	-------------------------
Second Session 10:45 - 12:00 a.m.	Films "Desk for Billy" "Migrant Families"	Audio-Visual Equipment Demonstration - Ralph Diaz - Lucy DuCharme - Beth Stevenson - Alice Woods	Project Information & Question-Answer Period -Rosabelle Blake -Ralph Diaz -Julian Shaw
Lunch 12:00 - 1:30 p.m.	-------------------------	---------LUNCH---------	-------------------------
Third Session 1:30 - 3:00 p.m.	"Meeting the Physical Needs of Migrant Children" - W. R. Ausley	Communication and Social Value - Margaret Flanagan Moderator - Beth Stevenson - Alice Woods - Rebecca Keith - Hazel Skjellum - Lucy DuCharme - Joe Mitchell	Workshop Evaluation 3 Groups 30" Session Group Reports - 30" Completion of Travel Forms - 30"

nursing, and dental services. Referral services for mental health, orthopedic, cancer, heart, rehab., blind, deaf, and mental retardation are available. Added services are evening family planning clinics, prenatal dental care, cancer detection, intensified TB and VD detection, TB chemoprophylaxis and screening for asymptomatic bacteruria in pregnancy.

Health education includes teaching, demonstrations, pamphlets, movies, discussions, and conferences by all staff. Sanitation has improved. Several of our smaller cities have installed sewage disposal facilities so that individual migrant housing is covered. A number of clean-up campaigns have been conducted. Stress has been placed on cooperation between owner and rentor.

A good bit of administrative time has been spent compiling statistics for reporting. In general, I believe we have increased our momentum toward and have succeeded in a better achievement of our objectives of:

(1) Improved preventive and medical care services

(2) Improved general sanitation and housing

(3) Coordination and cooperation in betterment programs

SETH MCKEEL
DISTRICT 1

W. RALPH DURRANCE
DISTRICT 2

WALTER O. GIBSON, JR.
DISTRICT 3

A. T. RACE, JR.
DISTRICT 4

WENDELL H. WAT ON, CHM.
DISTRICT

THE BOARD OF PUBLIC INSTRUCTION
FOR THE COUNTY OF POLK
P. O. BOX 391
BARTOW, FLORIDA 33830
TELEPHONE 533-3101

SHELLEY S. BOONE
SUPERINTENDENT

December 18, 1967

Mrs. Nell Hughes
Polk County Health Department
Winter Haven, Florida

Dear Mrs. Hughes:

Please allow us this means of thanking you for your valuable contribution in our recent workshop for migrant children.

From all the comments we have heard and our evaluation reports the indication is that the conference was a huge success. We know that the part you had in the program made this possible.

We feel sure that the assistant teachers have a better understanding of our migrant program in Polk County, and that this will definitely improve the educational opportunities for these migrant boys and girls.

Most sincerely,

Julian M. Shaw
Coordinator of Secondary Instruction

Rosabelle Blake

Rosabelle Blake (Mrs.)
Supervisor of Instruction

JMS:RB/bsw

JAMES A. RHODES, Governor

EMMETT W. ARNOLD, M.D.
Director of Health

450 East Town Street
P.O. Box 118
Columbus, Ohio 43216

State of Ohio

Department of Health

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October 31, 1967

Mrs. Nell Hughes
Health Educator
Polk County Health Department
P.O. Box 1480
229 Avenue D. N. W.
Winter Haven, Florida 33880

Dear Mrs. Hughes:

The slide series on Home Sanitation is available from Whites Camera Shop at 1409 East Livingston Avenue, Columbus, Ohio 43205. The charge is 30¢ a slide. There are 35 slides in this series which would be $10.50. There would also be a 25¢ or 30¢ mailing charge.

We can send you a script for Home Sanitation at no charge.

Sincerely,

James W. Hickman

James W. Hickman
Supervisor
Creative Services

JH/ku

The slides were
purchased with
migrant funds

PUTNAM AND FLAGLER COUNTY HEALTH DEPARTMENTS

J. C. Brooks, Jr., M. D., Director

Area of PUTNAM County:	803 square miles
Resident Population:	33,000
Area of FLAGLER County:	483 square miles
Resident Population:	5,300
Migrant Health Project Staff:	1 Public Health Nurse 1 Clerk-Typist (Part-Time)

PRETEST DRAFT - 1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT
For May 1, 1967 through April 30, 1968
Date submitted May 20, 1968

PUTNAM & FLAGLER

PART I - GENERAL PROJECT INFORMATION

1. Project Title
A Program to Develop a Statewide Program of Health Services for Migrant Farm Workers and their Dependents in Florida

2. Grant Number (use number shown on approved application)
MG-18E (68)

3. Name and Address of Applicant Organization
PUTNAM & FLAGLER COUNTY HEALTH DEPARTMENTS
Putnam County Health Department, Post Office Drawer 1070, Palatka, Florida 32077
Flagler - P.O. Box 57, Bunnell, Fla. 32010

4. Project Director
J. C. Brooks, Jr., M.D., Director
Putnam & Flagler Co. Health Depts.
Post Office Drawer 1070
Palatka, Florida 32077

5. Population Data - Number of Migrants (workers & dependents) for PUTNAM County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	1582	815	767
Under 1 year	54	31	23
1 - 4 years	79	46	33
5 - 14 years	126	79	47
15 - 44 years	497	203	294
45 - 64 years	643	401	242
65 and older	183	55	128
2. In-migrants			
Total	939	647	292
Under 1 year	27	6	21
1 - 4 years	31	16	15
5 - 14 years	53	19	34
15 - 44 years	251	199	52
45 - 64 years	376	261	115
65 and older	201	146	55

b. Number of migrants by month: Approximately

Month	Total	Month	Total
Jan.	2700	Jul.	52
Feb.	2700	Aug.	52
Mar.	2716	Sep.	52
Apr.	2725	Oct.	93
May	2951	Nov.	1987
June	2951	Dec.	2069

c. Average stay of migrants in county:
Out-migrants: 30 weeks
from Nov. (mo.) through June (mo.)
In-Migrants: 27 weeks
from Jan. (mo.) through June (mo.)

d. Source of information and/or basis of estimates:
Records of crew leaders and from project records. Also from Farm Labor Representatives and School Principals.

6. Housing accommodations for PUTNAM County:

a. Camps

Maximum Capacity	Number	Occupancy (peak)
Less than 10 persons	2	14
10 - 25 persons	5	107
26 - 50 persons	4	184
51 - 100 persons	0	0
More than 100 persons	0	0

b. Other housing accommodations

Type	Number	Occupancy (peak)
Farms	0	0
Other locations	126	1360

c. Append map showing location of camps, roads, clinics, and other places important to project.

PRETEST DRAFT - 1967

Project No. MG-18E (68)
Date submitted May 20, 1968

Putnam & Flagler Counties

PART II - MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients: Total	Male	Female	Number of Visits
Total	25	20	5	39
Under 1 year	2	2		2
1 - 4 years	1		1	1
5 - 14 years	2	2		3
15 - 44 years	12	8	4	21
45 - 64 years	4	4		6
65 and older	1	1		3
Age Unknown	3	3		3

2. Patients hospitalized:

Age	Number of patients: Total	Male	Female	Hosp. Days
Total	4	3	1	60
Under 1 year	1	1		37
1 - 4 years	1		1	5
5 - 14 years				
15 - 44 years	1	1		12
45 - 64 years				
65 and older				
Age Unknown	1	1		6

3. Patients receiving dental services:

Item	Total	Under 15	15 and Older
a. Number of migrants examined: total			
Number of decayed, missing, filled teeth			
Average DMF per person			
b. Individuals requiring services: total			
Cases completed			
Cases partially completed			
Cases not started			
c. Services provided: total			
Preventive			
Corrective			
Extraction	21		7
Other			
d. Patient visits: total			

4. Immunizations provided:

Type	Incomplete series	Completed immunizations - by age: Total	Under 1 year	1 - 4	5 - 14	15 and older	Boosters, revaccinations
All types	21	178	59	85	11	8	15
Smallpox		15		9	1		5
Diptheria	6	26	14	11	1		
Pertussis	6	26	14	11	1		
Tetanus	6	40	14	11	1	4	10
Polio	3	42	17	21		4	
Typhoid		2			2		
Measles		27		22	5		
Other (specify)							

Pretest Draft
1967

CONTINUATION SHEET FOR PART I

FLAGLER COUNTY

Project No. MG-18E (68)
Date submitted May 20, 1968

5. Population Data - Number of Migrants (workers and dependents) for FLAGLER County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	1124	805	319
Under 1 year	24	11	13
1 - 4 years	19	7	12
5 - 14 years	37	21	16
15 - 44 years	407	306	101
45 - 64 years	541	397	144
65 and older	96	63	33
2. In-migrants			
Total	898	625	273
Under 1 year	7	4	3
1 - 4 years	11	7	4
5 - 14 years	9	3	6
15 - 44 years	451	301	150
45 - 64 years	371	279	92
65 and older	49	31	18

b. Number of migrants by month:

Month	Total	Month	Total
Jan	300	Jul	12
Feb	309	Aug	12
Mar	451	Sep	12
Apr	490	Oct	12
May	976	Nov	12
Jun	976	Dec	300

c. Average stay of migrants in county:

Out-migrants: 28 weeks
from Dec. (mo. through June (mo.)
In-migrants: 19 weeks
from Feb. (mo. through June (mo.)

d. Source of information and/or basis of estimates:
Records of crew leaders and from project records. Also from Farm Labor Representatives and School Principals.

6. Housing accommodations for FLAGLER County:

a. Camps

Maximum capacity	Number	Occupancy(peak)
Less than 10 persons	5	45
20 - 25 persons	7	146
26 - 50 persons	1	40
51 - 100 persons	0	0
More than 100 persons	0	0

b. Other housing accommodations

Type	Number	Occupancy(peak
Farms	3	375
Other locations	10	51

c. Append map showing location of camps, roads, clinics, and other places important to project.

5. Medical conditions found by physicians among outpatients, by age of patient:

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
I	Infective and parasitic dis.	137		20	25	71	7	14
	Tuberculosis	11		1	2	4	3	1
	Venereal Disease	12				9	2	1
	Measles							
	Infestation with worms	22		11	9	2		
	Dermatophytosis & other infections of skin							
	Other (T.B. Skin Tests)	92		8	14	56	2	12
II	Neoplasms	2				2		
	Malignant	1				1		
	Benign & unspecified	1				1		
III	Allergic, endocrine, metabolic, and nutritional dis.	30	2		1	5	11	11
	Diabetes	25			1	4	11	9
	Malnutrition	4	1			1		2
	Other							
IV	Dis. of blood and blood-forming organs	11				11		
	Anemias	11				11		
	Other							
V	Mental, psychoneurotic and personality disorders	6				4	2	
VI	Dis. of nervous system and sense organs	12	2		1	4	4	1
	Cerebro-vascular disease (stroke)							
	Eye Diseases	9	2			4	3	
	Dis. ear and mastoid pro.	2			1			1
	Other dis. of nervous system	1					1	
VII	Dis. of circulatory system	29				4	16	9
	Rheumatic fever	1				1		
	Diseases of the heart	9					5	4
	Hypertension & other dis. circulatory system	19				3	11	5
VIII	Dis. of respiratory system	84	2	11	5	28	31	7
	Upper respiratory	21	1	9	1	8	2	
	Influenza and pneumonia	3				2	1	
	Bronchitis	12	1	1	2	5	3	
	Other	5		1		4		
	X-rays	43			2	9	25	7

5. Medical conditions found by physicians among outpatients, by age of patient (cont'd.):

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
IX	Digestive system diseases	19			3	10	4	2
	Teeth and supporting structures	11			3	6	2	
	Gastroenteritis, colitis	7				4	2	1
	Other	1						1
X	Dis. of genito-urinary system	13				7	3	3
	Urinary system diseases	8				3	2	3
	Genital system diseases	5				4	1	
XI	Deliveries and complications of pregnancy	22			1	21		
	Complications of pregnancy	1				1		
	Deliveries	21			1	20		
	Compli. of puerperium							
XII	Skin diseases	11	1	4	4	1	1	
	Impetigo	6		3	2	1		
	Other	5	1	1	2		1	
XIII	Dis. of bones and organs of movement							
XIV	Congenital malformations	6	1	5				
XV	Dis. of early infancy	1	1					
XVI	Symptoms, ill-defined cond.	25	1	4	6	9	2	3
XVII	Accidents, poisonings, violence	19		1	2	9	7	
	TOTAL OF CATEGORIES I-XVII	427	10	45	48	186	88	50
SUPP	Special conditions, examinations, w/o sickness: total							
	Prenatal, postnatal care	21			1	20		
	Physical examinations	35	12	7	5	11		
	Immunizations	32	6	18	4	4		
	Surgical or medical after-care, follow-up	6				2	4	
	Fitting prosthetic devices							
	Other							
	Child Spacing	35				30	5	

Putnam & Flagler Counties

PRETEST DRAFT - 1967
Project No. MG-18E (68)
Date submitted May 20, 1968

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number	Services provided:	Number
a. Visits to homes	319	f. Health supervision, counselling, teaching, demonstrating care in homes	76
b. Total households served	301	g. "Sick call" (nursing clinics)	371
c. Visits to schools, day care centers: total	12	h. Referrals for medical or dental care: total	119
d. Migrants presenting health record on request (PHS 3652)	3	Within area: total	118
		Number completed	118
e. Migrants given health record	21	Out of area: total	35
		Number completed	28
bl. No. Individuals served: total	327	i. Other (specify) Hospital Verification	4

2. Sanitation services

Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	17	3	19	12	48	9	2	16
Urban or other locations	Approx. 376							

Table B. Inspection of living and working environment of migrants

	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	34	33	13	11
b. Sewage	37	41	28	21
c. Garbage and refuse	25	23	13	10
d. Housing	53	71	41	26
e. Safety	11	13	7	7
f. Food handling	12	16	26	24
g. Insects and rodents	9	11	4	3
h. Recreational facilities	3	3	1	1
Working environment				
a. Water	11	23	0	0
b. Toilet facilities	21	15	6	4
c. Other	5	5	1	0

* Locations - camps or other locations where migrants work or are housed

PUTNAM AND FLAGLER COUNTIES
Migrant Project Annual Report

Period Covered: May 1, 1967 -- April 30, 1968

In order to review our success in the project during the past year, the following objectives for the 1967-68 year need to be evaluated:

(1) Improve the general appearance of the migrant housing with assistance from the worker, crew leader, and owner.

(2) Encourage greater participation in our clinics.

(3) Be able to make more home and field visits to keep in closer contact with the needs of the worker.

(4) Increase use of films in schools.

(5) Conduct classes for migrants in a certain area pertaining to topics of interest to them.

(6) Continue on a larger scale mass T.B. and V.D. and diabetic screening.

(7) Continue to strive for better understanding and working conditions of migrants.

All of these objectives have been met to a substantial extent, with the exception of number five. Now we have available two locations that we needed for classrooms before, buildings that we may use for this purpose. One is located in East Palatka and the other in West Palatka. These two areas have high migrant concentrations.

Plans will be formulated with the assistance of the health educator on the state staff as to methods of procedure to carry out this project. This will be done beginning in the fall of 1968.

The ages of migrants have remained the same. There are not as many female workers this year because of the mechanization of much farm machinery, especially the "potato digger."

The cultural background remains about the same, with improved living conditions and an increased interest shown in the individual, some attitudes are changing.

A large number of the migrants in this area are residents of the area, with the exception of the months they "go up state." We have some Mexicans, Puerto Ricans, and Negroes. Many of these follow a certain route year after year. The Mexicans and Puerto Ricans come from Texas and southern Florida and then migrate to Virginia, New Jersey, Indiana, New York, and even Michigan and Wisconsin. Most of the Negroes leaving here go to North Carolina, Virginia, New Jersey, Delaware, or New York.

Earlier and more extended plantings of cabbage provided a longer harvesting season that actually has overlapped the potato harvest.

Potatoes were generally planted later because a late freeze last year destroyed some crops and severely damaged others, resulting in an unusual "cold-shy" attitude on the part of most growers. This, along with an excellent harvest, will probably put our out-migrants as much as two weeks late "going up the road."

This same freeze of last year resulted in a substitute planting of a considerable acreage of cucumbers, which in turn provided a large number of farm jobs because of the hand labor involved.

The mechanical potato digger has replaced almost 100 per cent of the "stoop" labor involved in harvesting potatoes. This has displaced whole families and hundreds of laborers - migrants and local, and by large, mostly women (who picked up potatoes). It has also done away with loading crews on field trucks and eliminated the man on the old digger. Thus, the migrant crews now are practically all used in the grading operation. The women are employed as graders and sewers (sewing up sacks) and the men as dumpers, buckers, weighers, loaders, and utility men. The large scale use of conveyers has eliminated as many as ten men from some graders as hand truckers.

The transition from field hand to grader crew has been proceeding at a consistent pace and now seems to be 100 per cent complete. The expected rash of machinery-involved accidents has not materialized. This, we feel, is due partly to timely warnings from crew leaders and to the fact that a varying percentage of migrants have always been used on the graders.

This switch to mechanization will probably have little immediate effect on the outflow of our home base migrants, since most other crops - beans, tomatoes, cherries, peaches, and apples - still require hand labor. It has, however, resulted in the elimination of field crews here and consequently several hundred women and older hands are no longer employed. These people now are available as orange pickers for the valencia (late) crop and this quite possibly will reduce the flow of in-migrants formerly brought here as pickers. We foresee no important change in health service needs as a result of this situation.

Migrants, up to the present, are being seen in our regular clinics. In Flagler County they are seen in general clinic on Monday from 9:00 until 12:00 noon and from 1:00 p.m. to 4:00 p.m. The general clinic in Putnam County is on Tuesday with the same hours being observed. Mother (prenatal, postnatal, child spacing) and infant clinic is held each Wednesday morning in the health department. On other days and at times when our Health Officer (doctor) is not in this clinic, we have a fee-for-service arrangement with local physicians, where patients may be seen on referral of a public health nurse. This has proven to be a very satisfactory arrangement.

Patients on referral may be seen on an emergency basis by a local dentist.

An emergency room fee-for-service arrangement is used in all three of our hospitals (two in Putnam, one in Flager). Only one hospital, Bunnell General in Flagler County, has worked out an acceptable plan for the in-service care of migrants.

One nurse paid by the project, along with the other department personnel, are involved in the care of migrant patients.

Plans are being formulated to initiate a night clinic in East Palatka this fall. This has been a dream for the past three years; now hopefully it will become a reality. A building owned by the Community Action Program will be utilized for this purpose. It is a fact that migrants do not want to lose time from work to attend day clinics and are usually greatly in need of medical attention before they seek help. Also, transportation is a problem, so we feel a clinic should be situated in a locality easily accessible to the people.

As stated before, the majority of our objectives for this year have been achieved with a greater degree of success than in past years. An increased effort has been made to provide services to migrants. The mobile chest x-ray unit has been used in locations accessible to the people. Mass blood testing and an increased number of skin-testing has been done right in the field or packing houses where the migrant is working. Family planning information has been given to migrants wherever they are contacted - home, clinic, field and so forth. "Pills" are being used by many, but with a family planning clinic being planned for insertion of Intrauterine Devices, a number of the migrants are interested in switching from the pill.

As a result of this year's work, it is practically a reality that our services will be within the reach of the migrant population.

NURSING

Eight public health nurses provided services for the migrant and his family during the 1967-68 season, as a part of their generalized program. One nurse is employed full-time on the project and the other seven spend a portion of their time on this program.

There is no other staff involved, either paid or volunteer.

The specific objectives and duties of the nurses are to encourage mothers to have their children immunized, to enlist prenatal and postnatal patients to attend clinic, to plan health programs for schools, to encourage child-spacing, and encourage good nutrition and follow-up T.B., V.D. and mental health patients. Referrals from other areas within the state and out-of-state are followed through by a nurse. Our program is set up to give the best possible nursing care and to meet the specific needs of the migrants.

The growers are very receptive to any ideas or plans presented to them to improve the health of the migrant. They are cooperative in planning time for migrants to be seen "on the job."

Several church groups have become interested in the problems the migrant has. Many groups donate clothing and books. Also, many individuals have asked to be taken on field trips to migrant areas. As yet this has not been done due to the time factor.

Consultation received from outside the project includes the nursing consultant and the nutrition consultant from the State Board of Health. Also giving valuable consultation was the assistant to the project director of the migrant health project.

There are numerous problems encountered in providing nursing services to migrants and their families. The camps are located a considerable distance from one another and in many cases far removed from the health departments. They are also in low-income areas. Also, we must cope with the low educational level of the migrant. Their finances are limited; therefore they cannot purchase many needed items. As mentioned before, the distance the nurse has to travel is great; covering two counties, and this does not leave a great deal of time to spend with migrants in doing home and field visiting. Some of these problems could be solved with more health education, which is included in our general line of work.

The relationship between project and health department staff members and migrants has improved over the years. We feel the migrant more readily accepts help and advice from the health department personnel than before. In camps we carry on a continuing education program. In our visits we talk with the migrants and try to help them understand why we are interested in their health and well-being and how they can provide much of this self-help.

As states elsewhere, we have a referral system set up with local physicians and a dentist and one hospital. The referral is initiated by the doctor or a nurse. They are well accepted and the project has received excellent cooperation from those involved. The services are paid for on an accepted fee-for-service system, set up by the project and approved by those participating.

The routine out-of-state referral form is used. This method has proven very successful. The main reason for incomplete referrals is that the migrant does not go to the place he tells us. Also an inadequate address may be included as a reason for some failures. If the proper address, including the crew leader's name is included on the referral, a migrant is usually found on arrival in another location.

Several migrants have been referred to The Florida Council for the Blind, and Florida Crippled Children's Commission. These agencies provide transportation and follow-up on the patients. One weakness is the breakdown in care when the patient leaves the local area. Community groups still do not accept the migrant as a person. They continue to be looked upon as trouble makers. With night clinics and health education we may be able to change this line of thinking. Perhaps we will be able to enlist some volunteer help.

From the experience gained in this year's project, a night clinic will be added, we will continue to try to reach more migrants with our services, and continue to improve over-all relationships. One major need is for a dental preceptor.

One female migrant has requested referrals to a local physician many, many, times with various complaints - hemorrhoids, cramps, tooth-ache, pain in chest, hypertension, and high blood pressure. Her drug bill, alone, from December 21, 1967 to April 5, 1968 was $125.44. Each time the nurses see her coming through the door they wonder what's new. This individual is a prime example of a true hypochondriac - according to the physicians.

SANITATION

Two county health department sanitarians work part-time (5 - 10 per cent time involved) on migrant housing and related problems. Their duties include the permitting of larger camps, inspection of and visitation to all rental housing or so-called camp areas, fields, packing houses, and as much of the private housing as is practical. Objectives are simply to upgrade the environment to acceptable levels.

This work will continue for many years and it is most difficult to assess as to "proportion accomplished." There has been a general betterment of the camp areas and to a lesser extent of the private housing. The camps are well under control, but the private housing is scattered and can only be included in a general housing renewal and upgrading (which is a gradual process, but is taking place) rather than a clear cut migrant housing project.

Relationships with growers are usually cordial and cooperative in general. There are no known farm housing areas for migrants left, so the strain of trying to improve this particular problem has been eliminated.

Relationships with migrants are quite limited as most contacts are with the crew leaders. One exception involves personal housing, where an attempt is made to bring about improvements. This, so far, involves about 20 homes; 11 of which have added bathrooms and septic tanks and about 7 provided themselves with a pump and running water for the first time.

There are no established working relationships with farm labor representatives, extension agents, Farmers Home Administration, or community groups although all of these are cooperative. The Farmers Home Administration cannot aid a camp owner unless he is a farmer.

The Agriculture Research Service has offered some help to an existing camp for expansion.

Camps are now entirely of concrete block construction, all in fairly good condition. One camp has provided new family units and is planning more. This could possibly be considered as a trend.

Authority for issuance of permits: Sanitary Code of Florida, Chapter 170C-32.

Factors contributing to improvements in housing: The one camp large enough to be permitted has a very progressive and cooperative owner and improvements or corrections are limited only by economics.

Other camp areas are governed by general sanitation practices and common-sense application. One is installing central heat, an uncorrected defect of last year.

The improvements in private housing, we like to feel, are in some respect due to health education and practical explanations as put forth by the project staff and others in the health department.

There are a large number of migrants who have never been reached and of the many that have, only a very samll number react in a positive manner to general health and sanitation suggestions. This number is increasing gradually. There is still the problem of familiarizing many migrants with modern conveniences. To many, a flush toilet and a bath tub are mysteries.

In all of the camps, and in a goodly number of homes, running water is available. All camps have approved sewage disposal facilities. As mentionded, the long slow process of upgrading housing is gradually displacing the unapproved privies which have existed since time began.

The county operates land fills for garbage disposal. Even so, it is a problem for camps and homes alike, transportation being only one factor. A natural inclination to throw anything down anywhere and throw garbage out the back door for the dogs is a problem only partially solved so far.

All camps and practically all houses have refrigeration. A very few still rely on ice boxes.

Food handling in all camps is adequate. Insect control is sporadic rather than systematic. Screening is a continual problem. County mosquito control has decreased these pests considerably. Roaches in kitchens and living quarters are a general problem and it is here that the bug bomb and spray gun are relied upon rather than a more effective but more expensive commercial control contract.

Recreational facilities are limited. One camp provides a pool table and coin music box. All camps are within walking distance of beer halls and such other recreation as may be found in the community. All are within easy reach of a fishing spot.

Camps are kept fairly clean through efforts of the owners. Personal hygiene and cleanliness in living quarters is another continual problem that can only be resolved through long-term health education. This situation is acute in single men's quarters.

Adequate potable water is available at all known work locations. Usually a bubbler countain or paper cups are provided. In a few cases the dipper is still used. This practice is disappearing as much through demand of the workers as for any other reason. Here again, we believe this to be at least partially a result of efforts on the part of the project staff in health education.

Handwashing facilities are a problem in some farm locations, but all potato graders and practically all cabbage packing locations have some type available. These range from clean, new toilets with basins to yard spigots or flowing wells with ditched drainage.

Food handling is well provided for in all known cases. Usually the camp owner provides individual bag lunches for noon meals. One grader provides a lunch counter with hot meals. All are close enough to a town so that a worker can purchase a hot meal if he desires. Camp kitchens are generally well kept and are subject to inspection any time using Florida State Board of Health inspection form - "Food Service Establishment," Sanitation Code 413 (Rev. 7/63).

Toilet facilities are considerably improved, particularly in the potato graders. Field locations vary from new approved installations to old insanitary privies. These are slowly being phased out. Some people still simply refuse to associate the old privy way down on the back side of the field with anthropod-borne diseases, even though it may be only a few hundred yards from a new subdivision.

Health education has been directed principally at crew leaders and their wives in the belief that these are the most effective people in dealing with the migrants. This approach, we think, has brought about the best possible results so far.

There has also been some effort to educate growers concerning field sanitation and facilities at packing houses. There has been some improvement, but as noted, sanitation facilities in the field vary considerably.

There is no practical way to measure success in this field. We do know that until every farm and every packing house, every camp and every migrant home has approved sewage and trash disposal, plus potable water and each home can be accepted as an approved habitation, then we have not succeeded. We also know that until each and every person considered a migrant is aware of his personal responsibilities in regard to personal hygiene and general sanitation practices, then we have not succeeded.

We may apply a generalized percentage measure against the camps and say that we probably have met 80 per cent to 90 per cent of our objectives. We might also call this 100 per cent, as it must be considered there will always be some problems and some deficiencies where these people are concerned (broken screens and windows, trash disposal, fire hazards, toxic materials and so forth), so we now have probably achieved a maximum level of general sanitation.

To attempt to apply such a measure against private migrant housing is even more impractical. It is quite possible for a local home to make all improvements suggested by this department and the occupants not even be recognized as migrants.

Defects in camps are increasingly simple to correct. This is partly because of health education efforts by the project nurse, regular inspection, and usually the minor nature of defects since camps have improved. Basic problems involve field sanitation and private housing. In both cases, we run into the old bug-a-boo of ignorance.

Improvement of environmental sanitation practices will continue to be a major goal. Some procedure for identifying migrant housing will hopefully be worked out and will allow emphasis in that direction. Our efforts will continue in regard to improvement of field sanitation.

PROJECT OBJECTIVES FOR 1969

(1) To continue to improve the health and living conditions of the migrants.

- a. By establishing night clinics
- b. Enlarging existing clinics

(2) To increase services of the urban Negro and seek out migrants living in this area.

- a. By contacting crew leaders and trying to inform them of available services.
- b. By contacting growers to make them more aware of services offered.
- c. By more public health home visits.

(3) Expanding family planning services.

- a. By explaining the "pill" to all female migrants in the clinics and in home and field visits.
- b. By making them aware of the availability of an intrauterine device.

(4) To continue with V.D. and T.B. screening, and to increase diabetic screening.

(5) Increase environmental sanitation services.

    a. By accident prevention being taught in the home, field, and clinic.

(6) To utilize all available facilities and materials for health education.

SAINT LUCIE COUNTY HEALTH DEPARTMENT

Neill D. Miller, M. D., Director

Area of County: 601 square miles

Resident Population: 39,294

Migrant Health Project Staff:
1 Public Health Nurse
1 Senior Sanitarian
1 Clerk-Typist (Part-Time)

HEW-PHS
Wash.,D.C.

PRETEST DRAFT
1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT

For May 1, 1967 through April 30, 1968
Date submitted May 15, 1968

PART I GENERAL PROJECT INFORMATION

1. Project Title
A Program to develop a statewide program of health services for migrant farm workers and their dependents in Florida

2. Grant Number (use number shown on approved application)
MG-18E (68)

3. Name and Address of Applicant Organization
St. Lucie County Health Department
Post Office Box 580
Fort Pierce, Florida 33450

4. Project Director
Neill D. Miller, M.D., Director
St. Lucie County Health Department
Post Office Box 580
Fort Pierce, Florida 33450

5. Population Data - Number of Migrants (workers and dependents) for St. Lucie County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	5405	3530	1875
Under 1 year	75	30	45
1 - 4 years	200	110	90
5 - 14 years	900	500	400
15 - 44 years	3000	2000	1000
45 - 64 years	1100	800	300
65 and older	130	90	40
2. In-migrants			
Total	2930	1760	1170
Under 1 year	30	20	10
1 - 4 years	100	60	40
5 - 14 years	400	250	150
15 - 44 years	1300	750	550
45 - 64 years	1000	600	400
65 and older	100	80	20

b. Number of migrants by month:

Month	Total	Month	Total
Jan	4845	Jul	350
Feb	7500	Aug	350
Mar	4850	Sep	1000
Apr	4500	Oct	1500
May	4000	Nov	2000
Jun	350	Dec	3500

c. Average stay of migrants in county:
Out-migrants: 32 weeks
from Nov. (mo.) through May (mo.)
In-migrants: 24 weeks
from Dec. (mo.) through May (mo.)

d. Source of information and/or basis of estimates: Florida Industrial Commission Farm Labor Office, Florida State Employment Service, County Agent - St. Lucie County, Crew Leaders **

6. Housing accommodations for St. Lucie County:

a. Camps

Maximum Capacity	Number	Occupancy(peak)
Less than 10 persons	0	0
10 - 25 persons	2	39
26 - 50 persons	1	40
51 - 100 persons	0	0
More than 100 persons	0	0

b. Other housing accommodations

Type	Number	Occupancy(peak)
Farms	0	0
*Other locations	30	300 minimum

Undetermined number of migrants are housed in private homes in the Lincoln Park Area. (See Map)

c. Append map showing location of camps, roads, clinics, and other places important to project.

*Lincoln Park Apts.

** - Superintendent of Public Instruction
Clinic Patients

PRETEST DRAFT
1967
Project No. MG-18E (68)
Date submitted May 15, 1968

ST. LUCIE COUNTY

PART II MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of visits
	Total	Male	Female	
Total	373	160	213	819
Under 1 year	39	13	26	81
1 - 4 years	51	24	27	102
5 - 14 years	64	38	26	100
15 - 44 years	165	44	121	322
45 - 64 years	49	38	11	175
65 and older	5	3	2	39

2. Patients hospitalized:**

Age	Number of patients			Hospital Days
	Total	Male	Female	
Total	39	28	10	228
Under 1 year	1		1	6
1 - 4 years	2	1	1	
5 - 14 years	4	3	1	24
15 - 44 years	18	12	6	108
45 - 64 years	14	12	2	84
65 and older	0	0	0	0

3. Patients receiving dental service:

Item	Total	Under 15	15 and older
a. Number of migrants examined: total	95	20	75
Number of decayed, missing, filled teeth-	***	***	***
Average DMF per person	***	***	***
b. Individuals requiring services: total	95	20	75
Cases completed	25	6	19
Cases partially completed	65	6	59
Cases not started	3	0	3
c. Services provided: total	448	52	396
Preventive	4	3	1
Corrective	1	0	1
Extraction	292	29	263
Other	11	3	8
d. Patient visits: total	140	17	123

4. Immunizations provided:

Type	Incomplete series	Completed immunizations, by age					Boosters, revaccinations
		Total	Under 1 year	1-4	5-14	15 and older	
All types	270	495	38	263	162	32	4
Smallpox	0	57	0	30	27	0	0
Diphtheria	85	113	5	68	40	0	2
Pertussis	60	85	5	50	30	0	0
Tetanus	85	145	5	68	40	32	2
Polio	40	70	5	40	25	0	0
Typhoid	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Measles	0	25	18	7	0	0	0
Other (specify)							

**this figure reflects only those patients known to the migrant clinic that have been hospitalized. It is understood thatt the total number of patients has been requested but this information is not available, according to Hospital Administrator. He has estimated that 10% of the total patients for the year are migrant and the average stay is 6 days...this would give total patients :5595/totall migrants:559, impossible to breakdown as to age & sex.

ST. LUCIE COUNTY

5. Medical conditions found by physicians among outpatients, by age of patient:

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
I	Infective and parasitic dis.	89	5	20	28	30	4	2
	Tuberculosis	5				2	2	1
	Venereal Disease	17				16		1
	Measles							
	Infestation with worms	46	2	17	27			
	Dermatophytosis & other infections of skin	21	3	3	1	12	2	
	Other							
II	Neoplasms							
	Malignant							
	Benign & unspecified							
III	Allergic, endocrine, metabolic, and nutritional dis.	27	5	8	8	3	2	1
	Diabetes	5	2				2	1
	Malnutrition	1	1					
	Other	21	2	8	8	3		
IV	Dis. of blood and blood-forming organs							
	Anemias							
	Other							
V	Mental, psychoneurotic and personality disorders	8			1	5	2	
VI	Dis. of nervous system and sense organs	14	3	1	4	4	2	
	Cerebro-vascular disease (stroke)							
	Eye Diseases	5				3	2	
	Dis. ear and mastoid pro.							
	Other dis. of nervous system	9	3	1	4	1		
VII	Dis. of circulatory system	17				7	9	1
	Rheumatic fever							
	Diseases of the heart	7				1	6	
	Hypertension & other dis. circulatory system	10				6	3	1
VIII	Dis. of respiratory system	68	9	23	10	16	8	2
	Upper respiratory	54	8	23	9	8	5	1
	Influenza and pneumonia	1				1		
	Bronchitis	2	1			1		
	Other	11			1	6	3	1

Pretest Draft
1967

5. Medical conditions found by physicians among outpatients, by age of patient (Cont)

ST. LUCIE COUNTY

ICD Class	Diagnosis or condition	Total	Age of Patient					
			Under 1 yr.	1-4	5-14	15-44	45-64	65 & older
IX	Digestive system diseases	28	4	5		17	2	
	Teeth and supporting structures	8				6	2	
	Gastroenteritis, colitis	16	4	5		7		
	Other	4				4		
X	Dis. of genito-urinary system	11	1		1	9		
	Urinary system diseases	1			1			
	Genital system diseases	10	1			9		
XI	Deliveries and complications of pregnancy	3				3		
	Complications of pregnancy							
	Deliveries	1				1		
	Complications of puerperium	2				2		
XII	Skin diseases	19	4	6	7	1	1	
	Impetigo	10	1	5	3		1	
	Other	9	3	1	4	1		
XIII	Dis. of bones & organs of movement	27			3	5	18	1
XIV	Congenital malformations	2		2				
XV	Dis. of early infancy							
XVI	Symptoms, ill-defined cond.							
XVII	Accidents, poisonings, violence	13	2		2	7	2	
	TOTAL OF CATEGORIES I-XVII	326	33	65	64	107	50	7
SUPP	Special conditions, examinations, without sickness:Total	6	3		2	1		
	Prenatal, postnatal care	1				1		
	Physical examination							
	Immunizations							
	Surgical or medical after-care, follow-up							
	Fitting prosthetic devices							
	Other							
	Planned Parenthood Clinic	53				53		

Pretest Draft
1967
Project No. MG-18E (68)

Date Submitted May 15, 1968

ST. LUCIE COUNTY

PART III NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number	Services provided:	Number
a. Visits to homes	36	f. Health supervision, counselling, teaching, demonstrating care	30
b. Total households served	50	g. "Sick call" (nursing clinics)	36
c. Visits to schools, day care centers: total	8	h. Referrals for medical or dental care: total	16
d. Migrants presenting health record on request (PHS 3652)	1	Within area: total	15
		Number completed	15
e. Migrants given health record	1	Out of area: total	10
		Number completed	8
		i. Other (specify) Home visit made	60
b.1 No. Individuals served	85	No one home	45

2. Sanitation services

Table A. Survey of housing accommodations of migrants

Housing accommodations	Total number	Number with Permits	Housing units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Minimum ~~Maximum~~ Number	capacity		Number	Maximum capacity
Camps	3	2	9	0	40	2	2	37
Urban or *other locations	30	30	30	30	300	0	0	0

Table B. Inspection of living and working environment of migrants

Item	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	Since we	were unable to	employ a migrant	sanitarian until
b. Sewage	May 1, 1968,	all services	were rendered	by our staff
c. Garbage and refuse	sanitarians	in the course	of their routine	work.
d. Housing	Migrant	services were not	segregated as	all work
e. Safety	was performed	on a community	basis.	
f. Food handling				
g. Insects and rodents				
h. Recreational facilities				
Working environment				
a. Water	No service	was rendered	in this area.	
b. Toilet facilities				
c. Other				

* Locations - camps or other locations where migrants work or are housed

ST. LUCIE COUNTY

PART IV - GENERAL INFORMATION

Period covered by this report: May 1, 1967, through April 30, 1968

Objectives as listed in previous reporting period:

(1) To make comprehensive medical care available to the migrant population.

(2) To make dental service, primarily emergency care, available to the migrant population.

(3) To increase nursing services to the migrant population.

(4) To upgrade the environmental health conditions of the migrant population.

At the time of our last annual report we had yet to experience a clinic session as the first one was not held until June 6, 1967. During this reporting period we were unable to fill the Senior Sanitarian position for our complete migrant team. We do have the position filled, effective May 1, 1968. In view of this our project objectives for the new report period are basically the same as for last year:

(1) To make medical and hospital care available to the migrant and his family.

(2) To provide comprehensive and emergency dental care for the migrant population.

(3) To increase our nursing service to the migrant.

(4) To upgrade environmental health conditions of the migrant population.

(5) To develop and implement a health education program, especially making the migrant aware of the medical and dental services available to him and his family and teaching him to use these services to provide better health and living conditions.

Since we have not had a previous year of experience with which to compare this reporting period, it would be impossible to note any changes in the type of migrant served. All ages were treated, from small babies to age 65-plus; family groups were treated; they were predominantly Negro; however, White and Indian patients were also treated. More males than females were treated and at least 90 per cent were handicapped by a lack of formal education. Most migrate to this area from New York, Pennsylvania, New Jersey, North Carolina, and South Carolina. A large percentage of them cannot give a permanent address as they do not have a permanent home. Where do they plan to go from here? Most of them cannot give a definite answer to this question. They drift with a group or follow their crew leaders, working their way north with the crops but most of them seem to end their working season in the north in New York or New Jersey during the month of October and then return to the Florida area in November.

Weather has a strong effect on the economic situation and the market conditions resulting in different beginning and ending dates of "season," but generally the migrant stays in this area from November through May. Principal crops locally are citrus fruits (oranges and grapefruit) and vegetables. Many of the migrants are taken by labor buses from Fort Pierce to counties south of the area that produce a large volume of vegetables. Vast acreages of oranges have been planted in recent years in this county by Minute Maid and other large corporations. When these groves reach production, it is anticipated that the demand for laborers in this area will increase greatly.

This area has changed gradually from the small independent farmer or grove owner to large corporations. Several machines have been introduced in this area for picking fruits and vegetables but so far they have not proven successful for volume harvesting. It is anticipated that such machinery will be improved and gradually introduced but they are not used in such volume now to replace the migrant laborer.

The above mentioned factors regarding increased production and the use of machinery in harvesting crops, especially citrus in this area, do not indicate any immediate threat to the migrant laborer. With the development of more successful mechanized equipment there is also an increased production. The migrant will continue to follow this type of employment, leaving his family here in many instances, while he follows the stream. Therefore, the continued need for medical service for these individuals, as well as the migrant who comes to this area for a temporary work season, is apparent.

Medical and dental services during this year have been the main accomplishments of the project operation. Family health service clinics provide the basic health needs for the migrant. These services are adjusted to the socio-economic characteristics of this group. The project clinic is primarily to bring medical, dental, sanitation, and health education to these individuals.

The clinical services are provided in a leased structure located at 813 North 13th. Street, Fort Pierce, Florida, in a strategically located area, near to our local health department and yet readily accessible to the people for whom it is intended to serve. The facilities consist of a large waiting room, two examining-treatment rooms, an office completely equipped as a dental unit; including x-ray and dark room, locked storage area with ample space for supplies, educational material, sample food, milk, vitamins, etc.

All migrant clinic sessions are held in the evenings. The clinic office is also open two afternoon per week when the clerk is on duty. Medical clinics are held on Monday and Wednesday nights from 6:30 to 9:30. The dental session is held on Tuesday from 7:00 to 10:00 p.m.

Medical clinics are held as follows:

January	8 sessions	July	4 sessions
February	8 sessions	August	4 sessions
March	8 sessions	September	4 sessions
April	8 sessions	October	4 sessions
May	8 sessions	November	8 sessions
June	4 sessions	December	8 sessions

Dental clinics are scheduled as follows:

January	4 sessions	July	2 sessions
February	4 sessions	August	2 sessions
March	4 sessions	September	2 sessions
April	4 sessions	October	2 sessions
May	4 sessions	November	4 sessions
June	2 sessions	December	4 sessions

ST. LUCIE CLINIC ATTENDANCE

Clinic Date	Type	No. Patients	Clinic Date	Type	No. Patients
6/07/67	Medical	1			
6/15/67	Medical	5			
6/21/67	Medical	6			
7/05/67	Medical	12			
7/12/67	Medical	8			
7/26/67	Medical	19			
8/02/67	Medical	7			
8/08/67	Medical	11	8/08/67	Dental	1
8/23/67	Medical	4	8/15/67	Dental	1
9/06/67	Medical	3	9/12/67	Dental	1
9/20/67	Medical	3			
9/27/67	Medical	0	9/26/67	Dental	2
10/04/67	Medical	3			
10/11/67	Medical	4			
10/19/67	Medical	5			
10/25/67	Medical	4			
11/01/67	Medical	6			
11/10/67	Medical	2			
11/13/67	Medical	1			
11/20/67	Medical	4	11/21/67	Dental	4
11/22/67	Medical	11	11/28/67	Dental	4
11/27/67	Medical	3			
11/29/67	Medical	6			
12/04/67	Medical	2	12/05/67	Dental	5
12/06/67	Medical	5			
12/11/67	Medical	3	12/12/67	Dental	8
12/13/67	Medical	13			
12/18/67	Medical	4	12/19/67	Dental	10
12/20/67	Medical	15			
1/03/68	Medical	8	1/02/68	Dental	1
1/08/68	Medical	4			
1/10/68	Medical	19	1/11/68	Dental	13
1/15/68	Medical	12			
1/17/68	Medical	15			
1/24/68	Medical	21	1/23/68	Dental	6
1/29/68	Medical	5	1/30/68	Dental	10
1/31/68	Medical	28			
2/05/68	Medical	5	2/06/68	Dental	11
2/07/68	Medical	27			
2/12/68	Medical	7	2/13/68	Dental	13
2/14/68	Medical	31			
2/21/68	Medical	31			
2/26/68	Medical	8	2/27/68	Dental	11
2/28/68	Medical	19			

ST. LUCIE CLINIC ATTENDANCE - CONTINUED

Clinic Date	Type	No. Patients	Clinic Date	Type	No. Patients
3/06/68	Medical	27			
3/11/68	Medical	2			
3/13/68	Medical	20			
3/18/68	Medical	6	3/19/68	Dental	16
3/20/68	Medical	30			
4/01/68	Medical	8	4/02/68	Dental	18
4/03/68	Medical	36			
4/22/68	Medical	10			
4/24/68	Medical	44			
4/29/68	Medical	12	4/30/68	Dental	16

In addition to the clinic service available to the migrant, we also have the fee-for-service type of medical and/or dental care at which time the patient is seen in the office of a private physician or dentist.

The migrant project staff consists of one public health nurse, one clerk-typist, and a sanitarian (beginning May 1, 1968). We have two local physicians and one local dentist participating as clinicians in the program on a fee-per-clinic-session basis. At the present time, we do not have any volunteers or groups working on this project. Last summer several Vista workers assisted in setting up the clinic office but their office has now been closed in this area.

During the past year health education has been a part of this program and was provided by the project nurse as she functioned in the clinical setting and as she made home visits to the crew leaders and the migrant himself. In addition to this, health education is a part of the prenatal, planned parenthood, tuberculosis control, venereal disease control, and immunization clinics that are held once a week in our local health department and is provided by our public health nurse and the private physicians who serve as clinicians during these clinics.

During this past year there were 24 migrant patients referred to other physicians for additional or special care or treatment. One of these referrals was found to have active tuberculosis and was admitted to Southeast Florida Tuberculosis Hospital. Another was an eight-year-old boy who fell down an embankment while he was up-state during the season. Since he did not have any complaints at that time the family did not seek medical care for him. He returned here late in the fall of 1967 and shortly thereafter began to experience convulsions and abnormal behavior during these attacks. The boy was hospitalized by the clinician and later referred to a neuro-surgeon in West Palm Beach, Florida, whose finsings revealed a hairline fracture of the skull with some degree of decompression.

Since we have not completed a full year of operation, no definite changes are suggested at this time. Any changes needed in the future will be made after we have the opportunity to evaluate our program at the completion of a year of service.

To receive outpatient care and/or emergency services, which cannot be provided at the migrant clinic or other health department clinics, the project reimbursed the Ft. Pierce Memorial Hospital for migrant services at an all-inclusive rate of $10. per visit.

The Inpatient Hospitalization component of our migrant project was just inaugurated in March, 1968. A total of five patients had been hospitalized by the end of this reporting period. One of the first migrant patients hospitalized was on March 19, 1968. A colored male who came to this area in October, 1967, from Chesterfield, New Jersey, to work in local crops was hospitalized because of second degree burns covering a large part of his body. He received these burns when he went into a burning frame dwelling and rescued three unattended children. Our migrant project was able to pay a percentage of his bill for thirty days of his hospitalization. His total bill for the 33 day period was $1,123.20. This man continued to be hospitalized following the 30 day period paid for by the migrant project.

As evidenced in the budget, there is a great need to increase the amount of support from the Public Health Service for hospitalization for the migrant because these people cannot pay for these services. This is particularly important because these people do not meet the local residency requirements and therefore other resources are not available to them.

The figures shown in Part II, Section 2, reflect only those patients known to the migrant clinic that have been hospitalized. It is understood that the total number of patients has been requested, but this information is not available, according to the hospital administrator. He has estimated that 10 per cent of the total patients for the year are migrants and the average stay is six days each. This would give total patients as 5,595 and total migrants as 559. He claims that due to time limitations it is impossible to break down the number as to age and sex.

The migrant population is eligible for the usual services offered by a health department. These services include the following: a 70 mm x-ray clinic is held every Monday and on the fourth Monday of each month we have the added facility of a 14 x 17 diagnostic x-ray clinic. On the second Monday of each month, in addition to the services already listed, we have a regional tuberculosis clinic serving Martin, Okeechobee and St. Lucie counties. It is staffed by a physician and a public health nurse. On each Tuesday there is a prenatal clinic. This clinic is for those who are planning to have a midwife delivery. Service is provided by local physicians on a rotating, volunteer basis and by a public health nurse. A planned parenthood clinic is held on the first and third Wednesday morning of each month and the second and fourth Wednesday evening of each month. They are staffed by a local physician on a fee-for-service basis and by nurses from the health department. Venereal disease clinics are held every Friday morning. Care is provided by a local physician on a fee basis and by staff nurses of the health department. A general immunization clinic is held every Friday afternoon. The services of the Florida Crippled Children's Commission regional clinic are available to the migrant. Just recently instruction in personal hygiene, good nutrition, and safety in the home has been introduced to the migrant group.

There is a close working association between the migrant project personnel and other local agencies or groups, especially the County Welfare Association, Lincoln Park Child Care Center, Tuberculosis and Respiratory Association of Southeast Florida and the American Cancer Society.

One example of cooperation of another agency is as follows: A young baby was brought to the migrant clinic for medical examination. The baby's entire body was covered with an extreme eczema, the skin in such a severe condition that it resembled rough alligator skin. The baby was given a complete examination and the clinician prescribed a meat-base formula instead of milk. This formula could only be purchased at a drug store but could not be classed as a drug. Therefore, our migrant project could not provide funds to purchase the formula needed for the baby. The migrant nurse checked several sources to provide this formula which the mother of the baby said she could not afford to buy. The condition of the baby continued to grow worse. Finally, through the cooperation of the County Welfare Department, with the migrant nurse, funds were secured to purchase the prescribed formula. The baby was checked periodically by the clinician during migrant clinic sessions and continued to show improvement. The Welfare Department continues to supply the formula. The physician has discontinued the formula for brief periods but the skin condition immediately worsens.

A more complete understanding of the services provided by the migrant project for workers by the crew leaders is of prime importance and is an area in which much effort must be put forth by all project staff members. These crew leaders are in a key position to inform and help the migrant. We have a good relationship with the growers in this area as they realize how important it is to keep the migrant worker in good health.

Our project nurse and one of our clinicians have attended meetings for migrant project staff members in Miami and Orlando, Florida. These were very helpful and informative. One of our physicians who serves as a clinician attended the conference held in Orlando recently. This gave him a much better understanding of the complete program and his enthusiasm and interest in the migrant and his family problems has increased tremendously.

Our objectives, as outlined in our first report, have been achieved in even greater depth than we had thought would be possible for the short time we have been in operation and considering some of the problems that we have faced during this year. We had a change in nursing personnel which meant training a second nurse in the project procedure within a three-month period. Not having a sanitarian was a great handicap to us during this year's operation. The most rewarding factor has been the complete dedication to this cause that has been shown by doctors, dentists, project staff, and the staff of our health department. They have all accepted this as a personal challenge and tried for achievement of our goals and objectives. An increase in the number of personnel and in operating funds would result in more complete and comprehensive health services for the target population.

In order to accomplish our goals for the new reporting period, we now have a complete working team. We hope to reach more of the families of the migrant who need medical and dental attention. There is such a great need for emergency dental work to be done that it has not been possible to give attention to preventive or corrective dental work. The dentist who serves as a clinician states that the majority of the patients treated in the clinic had never been to a dentist before. There has been almost no time for corrective or preventive work. The need is so great for extractions that this has taken priority. During a dental clinic session of approximately three hours, as many as 35 people have been examined and sometimes four to five extractions per person are necessary.

It is hoped that some time can be given to this. Because of the limited amount of funds for hospitalization of the migrant and his family, we will be limited in the amount of progress that can be made in this area. With the services of a sanitarian available now, we feel that much progress can be made in upgrading the environmental health conditions of the migrant and his family.

One of the most important areas to be developed in our program for the coming year is in health education. It is important that we improve the health and living conditions of the migrant and his family but it is even more important that we show them a better way of life and create in them the desire to have better food, housing, and working conditions.

Because of the shortage of personnel during the past year, health education was one of the weaknesses of our program. Plans can now be carried out to overcome this. It is important to educate the migrant and his family, but it is also important to make the community aware of the needs of these people, of the services provided by the migrant project and of the support that is needed from others. There is a tremendous potential in the field of family planning. Many migrant men are reluctant to discuss methods with nurses. Here the environmental health personnel can be of great assistance.

The Migrant Health Program is now firmly established in the community and during the coming year every effort will be made to obtain the full benefit of funds and services available.

NURSING SERVICES

The migrant clinic staff consists of one full-time public health nurse, one senior sanitarian (effective May 1, 1968), one clerk-typist II, two physicians, and one dentist serving as clinicians on a fee-for-service basis. For a short time last summer we had the services of the Vista volunteers who helped to a great extent in getting the message about the Migrant Health Project and the services of the migrant clinic to those who were eligible for this care.

Our specific objectives were to make available to the migrant and his family basic health services; primarily medical, dental, and health education services. These objectives were achieved by the establishing of one medical clinic per week and one dental clinic every other week during the months of June, July, August, September, and October. These sessions were increased to two medical clinics and one dental clinic per week during the remaining months of the year. The clinics are held at night and are free of charge to all migrants and their immediate families.

The direct personal contact by the migrant project nurse with the crew leaders specifically greatly facilitated communications. These people, understanding their own associates, were able to communicate with the migrant to a far greater extent than the staff personnel. Once the migrant attends a clinic, receives the help that he needs, is assured by the clinic nurse that he will not have to pay for his service, he establishes his personal confidence in the staff of the clinic.

As we complete an evaluation of a total year's project, we will be more able to define our needs regarding consultation needed.

The migrant project nurse provided direct service to the migrant and his family by assisting in the medical and dental clinics.

The medical clinics included the following health services: Communicable disease contact, prenatal care, venereal disease control, family planning, tuberculosis control and case finding, child care service, intestinal parasite control, etc.

Home visits are made in the interest of the migrant by the nurse at which time a greater insight into his plight is gained.

One of the major problems encountered is the lack of communication on the part of these people. After several conferences with the nurse, or after attending clinic sessions, the migrant begins to respond to the efforts of the migrant clinic staff.

Health education has been a part of each clinic session and provided by the physician, the dentist, and/or the nurse. Beginning in March, 1968, we were fortunate in having the service of the regional nutrition consultant at the medical clinic sessions. Lectures, movies, and individual consultation were provided. This new service was very well received by the migrant and his family.

Referral of the migrant to other sources of service was varied. Arrangements for referral to physicians, dentists, hospital x-ray department, inpatient facilities, were made by telephone or by direct contact by the migrant nurse. We were fortunate in having completed referrals locally. The individuals cooperated well and all made an earnest attempt to carry out individual instructions.

We use the Migrant Health Service Referral system as often as possible. The migrant who has been following the crops for years knows the value of the referral system and will take the opportunity to tell you he is leaving the area and at the same time give you the necessary information. However, in our local area where our migrants are not camp based, and often decide over a weekend to follow the crops, we have devised a card that the migrant himself seems to think will be very helpful to him, especially if he is one who is traveling independent of a crew leader and would not be going to a specific migrant camp but working here and there in agriculture. We also issue the Personal Health Record. The identification care is credit card size. On the front it lists the name, address, and telephone number of our migrant clinic along with the name, age, sex, and social security number of the individual. On the reverse side it has space for remarks, i.e., patient is sensitive to penicillin injections, patient is known diabetic, etc.

After getting off to a slow start, mainly because the program was new and not fully understood by the majority of the population affected, it can be said that the service provided and the cooperation of other resource agencies was adequate. The project nurse provided continuity of care by utilizing related resources provided by the Welfare Departments, Commodity Food Service, county health department, etc. Efforts to motivate groups to share in upgrading life of the migrant have been made and will continue to be a part of the education program.

SANITATION SERVICES

With the recent employment of a Senior Sanitarian, this now completes our roster of personnel. We feel we will not be able to carry out a subjective program during the coming year. During the past year all services rendered the migrant have been by the staff sanitarians in the course of their daily routine work. Practically no migrants live in the rural areas of the county since they prefer to live in the populated areas of the city. The Lincoln Park area of Fort Pierce is the center of population. The migrant buildup in the area is gradual during November, December, and January when the outmigrant return from the trip north. The inmigrants begin to appear in January and gradually increase in numbers until May, when the peak is reached. During this time, the staff sanitarians have investigated or inspected on a regular basis, housing; food service facilities; garbage and trash removal; sewage disposal; rest room facilities; animal bites; nuisance complaints; and water supplies.

It has been determined that the out-migrants all occupy private homes that they return to each year. The in-migrants occupy rooming houses that are primarily equipped for sleeping purposes only, as well as private homes. The landlords do not object to cooking in these rooms, but have not provided any facilities. This has presented numerous sanitation problems. To alleviate the housing problem, the grove owners have seriously considered construction of housing in the new grove areas. They now feel, after careful consideration, this would not be a wise move, since the Lincoln Park area of Fort Pierce seems to be more desirable to the worker, primarily from a social activity standpoint. The City of Fort Pierce, recognizing the problems in depressed areas within it's corporate limits, has qualified for federal housing aid by adopting a minimum housing code. At the present time, a low-rent housing project is under construction. The city has established improvement districts and work is now underway on the renovation of existing substandard structures. With a combination of these two projects, a definite upgrading of housing is quite apparent.

The newly employed migrant project sanitarian will make an all-out effort to survey the housing accommodations available to the migrant. After his survey is completed and the information evaluated, we will be in a much better position to determine the needs of the community from the standpoint of the migrant. We are well aware that problems now exist in the general area, but to what degree this may affect the migrant is unknown. We do know that there is a great deal of health education needed to better acquaint the migrant with ways he may help himself. Once we are able to convince him there is a better way of life than the one he now pursues, we feel he will have some degree of pride, in expecting, seeking, demanding, and obtaining a better environment in which to live.

Lincoln Park Housing Available to Migrants

We have contacted the City of Fort Pierce License Department and the Florida State Hotel and Restaurant Commission to obtain information on housing available to migrants. The City License Department furnished us with a list of 28 establishments having five or more rooms or living units per building that are available for renting on a weekly basis. The Hotel and Restaurant Commission has furnished us with a list of 30 establishments that have five or more rooms or living units per building that are licensed as rooming houses. Since each organization has approximately the same number of establishments licensed, we feel this is a reliable figure. Florida Statutes provide that a license may not be issued by a municipality on establishments under the supervision of the Hotel and Restaurant Commission until it meets their regulations. This information was available only on rooming houses in the Lincoln Park area of Fort Pierce and does not include rental housing of less than five units or rooms.

We feel sure that quite a number of private homes rent rooms during the season and furnish meals with these rooms. The migrant who lives in these homes may even become part of the family and be recognized as the head of the house or principal breadwinner.

Since the rooming houses were licensed on the basis of five or more rooms or units, and did not list the total number available, we have arrived at approximate figures only. Based on the 30 licenses issued on a minimum of five units each, we have 150 units. Using the State Health Department's accepted rule of thumb for occupancy of two persons per room, we arrive at a figure of 300 persons.

Now that we have a full-time sanitarian employed, who will actually be checking these rental units, we feel that next year we will have accurate figures in total units available and the occupancy of each. This will eliminate the future approximating of numbers.

Decline in Migrant Population 1967-1968

The general trend of migrant population in the area seems to be decreasing. As well as we can ascertain, this is brought about by two chief factors. First, the migrants of our area are not able to find work in vegetables to the degree they can in other areas. Since working vegetables is more lucrative than working citrus, they prefer this type of work. If they are to be engaged in vegetable harvesting, they must travel long distances; which in many instances may increase the hours of a working day by one-half. If they live nearer to the fields in Devil's Garden or other distant places they have more free time, so it is only logical that they would move near to their work. The second reason is mechanization of harvesting. Since hand harvesting is slow and unreliable, the growers tell us they are forced into investing in various types of mechanical equipment that will be readily available at harvest time. This seems to be very important in farming as many types of row crops are perishable and must be harvested in a very limited period of time. Also, the market is so flexible that the difference between success and ruin of a particular crop would be harvesting and delivering to the market place at the most desirable time, when the price is at a high level.

Population Survey

We were unable, due to existing circumstances, to conduct population surveys of field workers as we did last year. Fortunately, we were able to solicit aid from a reliable source in the agricultural labor field that has provided us with information. We first contacted the county agent's office, who referred us to the Florida Employment Service, who referred us to the Florida Industrial Commission Farm Labor Office, where the following information was obtained.

At the peak of the citrus harvesting season, there were 750 workers in citrus and 250 workers in vegetables. Since this time, the numbers have declined in citrus but increased in vegetables. The average has remained practically the same but in the reverse order. In addition to these workers, we also have the women of the area who annually work in the vegetable fields earning money to supplement the family income. At the present time, this number is small due to poor growing conditions resulting from a lack of rainfall. It is estimated that the crop will be light and the number of workers will be less than last year.

Labor Camps

A survey of the labor camps in the county indicates that this year, as last, there are few migrants living in the housing provided. Of the six camps we found, one the Offshore Quarters Camp - converted into a rooming house - since we have no offshore labor. No migrants were found in two camps, Minute Maid and Ideal Holding; fifteen in the DiGiorgio Okeechobee Road Camp during March, April and May, and twenty in DiGiorgio #2 Camp from November through April. There was one camp (Bowen Brothers) that was occupied exclusively by migrants from Texas who had brought their families with them. This camp was occupied during January, February, March, and April by nine families with a total population of 40 persons. Since making our survey this camp was completely destroyed by fire, and most likely will not be rebuilt.

Since we were unable to employ a migrant sanitarian until May 1, 1968, all services, including inspection of living and working environment of migrants, were rendered by our staff sanitarians of the county health department in the course of their routine work. Migrant services were not segregated as all work was performed on a community basis. In regard to water, sewage, garbage and refuse, housing, safety, food handling, insects and rodents, recreational facilities and toilet facilities, we find conditions in varying degrees from good to poor. These areas will be explored in detail during the coming year by the newly employed migrant sanitarian.

SARASOTA COUNTY HEALTH DEPARTMENT

David L. Crane, M. D., Director

Area of County:	586 square miles
Resident Population:	95,000
Migrant Health Project Staff:	1 Public Health Nurse 1 Health Educator 1 Clerk-Typist (Part-Time)

PRETEST DRAFT - 1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT

For MAY 1, 1967 through APRIL 30,1968

Date submitted MAY 15, 1968

PART I - GENERAL PROJECT INFORMATION

1. Project Title

A Project to develop a statewide program of Health Services for Migrant Workers and their dependents in Florida.

2. Grant Number (use number shown on approved application)

MG18E (68)

3. Name and Address of Applicant Organization

Sarasota County Health Department
1938 Laurel Street
P.O. Box 2658
Sarasota, Florida 33578

4. Project Director

David L. Crane, M.D.

5. Population Data - Number of Migrants (workers & dependents) for Sarasota County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	500	254	246
Under 1 year	25	11	14
1 - 4 years	48	28	20
5 - 14 years	210	85	125
15 - 44 years	140	80	60
45 - 64 years	60	40	20
65 and older	17	10	7
2. In-migrants			
Total	2000	1109	891
Under 1 year	30	14	16
1 - 4 years	79	35	44
5 - 14 years	98	47	51
15 - 44 years	1200	650	550
45 - 64 years	500	300	200
65 and older	93	63	30

b. Number of migrants by month:

Month	Total	Month	Total
Jan.	2500	Jul.	1000
Feb.	2500	Aug.	500
Mar.	2500	Sep.	500
Apr.	2000	Oct.	850
May	2500	Nov.	1000
June	2000	Dec.	2000

c. Average stay of migrants in county:

Out-migrants: 16 weeks

from June (mo.) through Sept. (mo.)

In-Migrants: 24 weeks

from Jan. (mo.) through June (mo.)

d. Source of information and/or basis of estimates: Surveys, Clinics, Payroll, and personal contact by personnel and volunteers.

6. Housing accommodations for SARASOTA County:

a. Camps

Maximum Capacity	Number	Occupancy(peak)
Less than 10 persons		
10 - 25 persons		
26 - 50 persons	1	40
51 - 100 persons	1	60
More than 100 persons	2	200 plus

b. Other housing accommodations

Type	Number	Occupancy(peak)
Farms		
Other locations	25	2200

c. Append map showing location of camps, roads, clinics, and other places important to project.

PRETEST DRAFT - 1967

Project No. MG18E (68)
Date submitted MAY 15,1968
SARASOTA COUNTY

PART II - MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:

Age	Number of patients			Number of Visits
	Total	Male	Female	
Total	623	308	315	897
Under 1 year	48	32	16	98
1 - 4 years	126	67	59	180
5 - 14 years	85	46	39	150
15 - 44 years	277	117	160	337
45 - 64 years	73	37	36	110
65 and older	14	9	5	22

2. Patients hospitalized:

Age	Number of patients			Hosp. Days
	Total	Male	Female	
Total	25	15	10	67
Under 1 year	8	4	4	23
1 - 4 years	12	9	3	24
5 - 14 years				
15 - 44 years	5	2	3	20
45 - 64 years				
65 and older				

3. Patients receiving dental services:

Item	Total	Under 15	15 and Older
a. Number of migrants examined: total	18	3	15
Number of decayed, missing, filled teeth	72	12	60
Average DMF per person	4	4	4
b. Individuals requiring services: total	18	3	15
Cases completed	15	3	12
Cases partially completed	3		3
Cases not started			
c. Services provided: total	2		2
Preventive			
Corrective			
Extraction	53		53
Other			
d. Patient visits: total	40	6	34

4. Immunizations provided:

Type	Incomplete series	Completed immunizations - by age					Boosters, revaccinations
		Total	Under 1 year	1 - 4	5 - 14	15 and older	
All types	268	222	10	85	29	10	88
Smallpox	6	16		10	6		
Diptheria	25	26	2	11	2		11
Pertussis	25	36	3	11	2		20
Tetanus	200	78	3	13	12	10	40
Polio	12	41	2	17	5		17
Typhoid							
Measles		25		23	2		
Other (specify)							

5. Medical conditions found by physicians among outpatients, by age of patient:

ICD Class	Diagnosis or Condition		Total	AGE OF PATIENT Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
I	Infective and parasitic dis.	*	37	4	17	6	6	3	1
	Tuberculosis		1		1				
	Venereal Disease		3				2		1
	Measles		2		2				
	Infestation with worms		12	2	7	3			
	Dermatophytosis & other infections of skin		14	2	4	2	3	3	
	Other MUMPS		3		1	1	1		
	GERMAN MEASLES		2		2				
II	Neoplasms	*	1				1		
	Malignant								
	Benign & unspecified		1				1		
III	Allergic, endocrine, metabolic, and nutritional dis.	*	17	1			5	11	
	Diabetes		8				2	6	
	Malnutrition		2	1			1		
	Other OVERWEIGHT		7				2	5	
IV	Dis. of blood and blood-forming organs	*	22	5	6	2	9		
	Anemias		22	5	6	2	9		
	Other								
V	Mental, psychoneurotic and personality disorders	*	3			1	2		
VI	Dis. of nervous system and sense organs	*	44	5	14	4	11	5	5
	Cerebro-vascular disease (stroke)								
	Eye Diseases		16	2	1	1	6	3	1
	Dis. ear and mastoid pro.		28	3	13	3	5	2	4
	Other dis. of nervous system								
VII	Dis. of circulatory system	*	32				8	21	3
	Rheumatic fever								
	Diseases of the heart		2					2	
	Hypertension & other dis. circulatory system		30				8	19	3
VIII	Dis. of respiratory system	*	152	27	62	21	32	7	3
	Upper respiratory		123	24	50	12	31	5	1
	Influenza and pneumonia		8		2	5	1		
	Bronchitis		17	3	9	3		2	
	Other ASTHMA		4		1	1			2

5. Medical conditions found by physicians among outpatients, by age of patient (cont'd.):

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
IX	Digestive system diseases *	58	8	13	8	19	6	4
	Teeth and supporting structures	19		2	3	7	4	3
	Gastroenteritis, colitis	39	8	11	5	12	2	1
	Other							
X	Dis. of genito-urinary system	31				30	1	
	Urinary system diseases	8				7	1	
	Genital system diseases	23				23		
XI	Deliveries and complications of pregnancy	1				1		
	Complications of pregnancy							
	Deliveries	1				1		
	Compli. of puerperium							
XII	Skin diseases *	12		1	2	5	4	
	Impetigo	1			1			
	Other ULCER-Skin (1)	11		1	1	5	4	
XIII	Dis. of bones and organs of movement *	15				8	6	1
XIV	Congenital malformations	1	1					
XV	Dis. of early infancy							
XVI	Symptoms, ill-defined cond. *	20	4		5	10		1
XVII	Accidents, poisonings, violence *	19		6	4	7	1	1
	TOTAL OF CATEGORIES I-XVII **	465	55	119	53	154	65	19
SUPP	Special conditions, examinations, w/o sickness: total **	150	10	11	19	102	8	
	Prenatal, postnatal care	7	1			6		
	Physical examinations	46	5	6	13	21	1	
	Immunizations	84	4	5	6	62	7	
	Surgical or medical after-care, follow-up							
	Fitting prosthetic devices							
	Other Planned Parenthood	13				13		

PRETEST DRAFT - 1967

Project No. MG18E (68)

Date submitted MAY 15, 1968

SARASOTA COUNTY

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number
a. Visits to homes	648
b. Total households served	62
c. Visits to schools, day care centers: total	5
d. Migrants presenting health record on request (PHS 3652)	2
e. Migrants given health record	110
b-1 Total No. Indiv. Served	315

Services provided:	Number
f. Health supervision, counselling, teaching, demonstrating care ~~homes~~	87
g. "Sick call" (nursing clinics)	25
h. Referrals for medical or dental care: total	114
Within area: total	91
Number completed	75
Out of area: total	53
Number completed	25
i. Other (specify) Vision & Hearing testing (App.)	125

2. Sanitation services

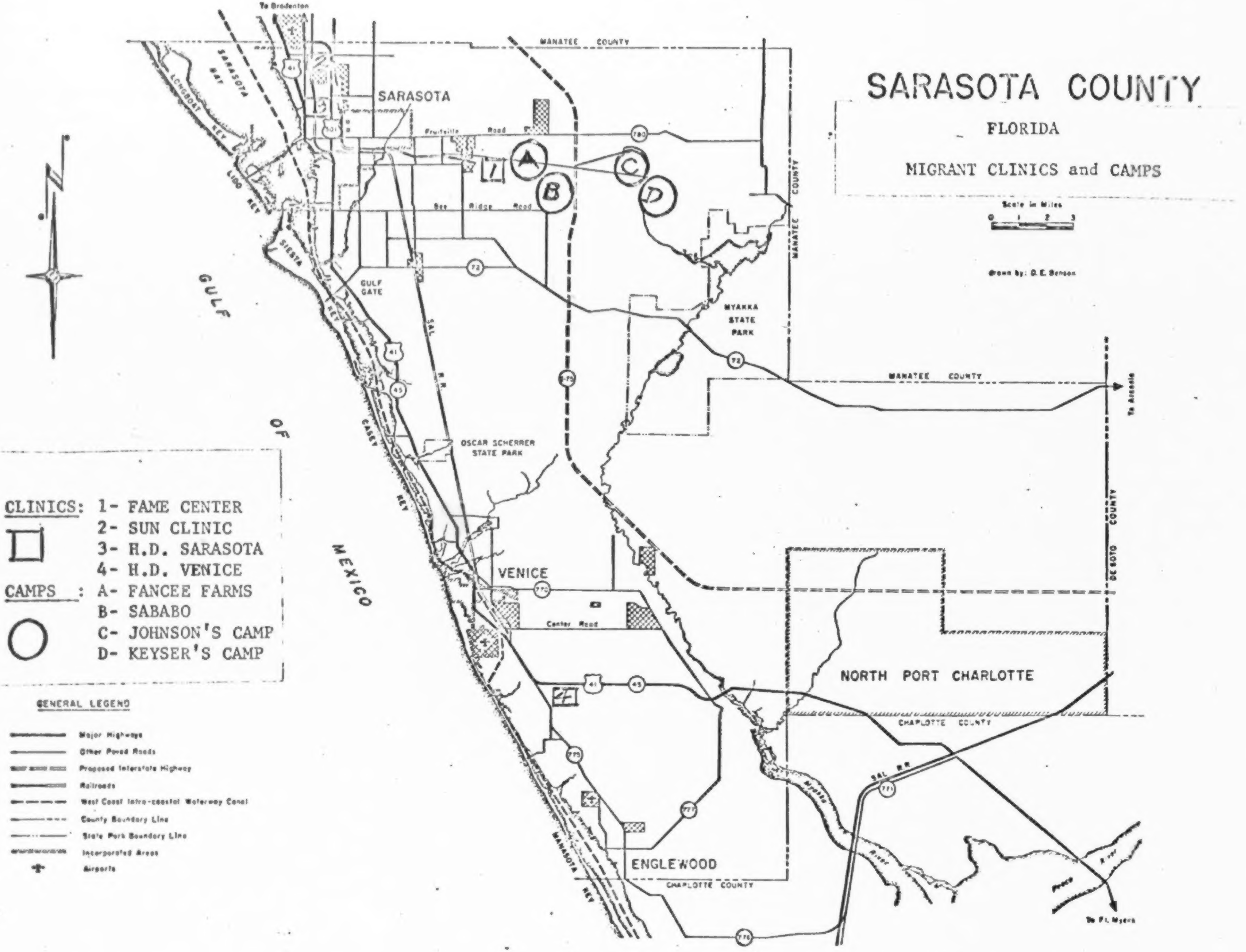
Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units: Total number	Housing Units: Covered by permits: Number	Housing Units: Covered by permits: Maximum capacity	Dormitories: Total number	Dormitories: Covered by permits: Number	Dormitories: Covered by permits: Maximum capacity
Camps	4	3	78	47	300	NA	NA	NA
Urban or other locations	25							

Table B. Inspection of living and working environment of migrants

	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	4	9	4	4
b. Sewage	5	8	2	2
c. Garbage and refuse	7	10	4	2
d. Housing	10	7	9	5
e. Safety	5	6	2	2
f. Food handling	1	2	2	1
g. Insects and rodents	5	7	4	2
h. Recreational facilities				
Working environment				
a. Water	1	1	0	0
b. Toilet facilities	3	4	3	
c. Other Child Care Center	1	3	5	2

* Locations - camps or other locations where migrants work or are housed



SARASOTA COUNTY

FLORIDA

MIGRANT CLINICS and CAMPS

Scale in Miles
0 1 2 3
drawn by: G. E. Benson
CLINICS: 1- FAME CENTER
2- SUN CLINIC
3- H.D. SARASOTA
4- H.D. VENICE
CAMPS : A- FANCEE FARMS
B- SABABO
C- JOHNSON'S CAMP
D- KEYSER'S CAMP
GENERAL LEGEND
Major Highways
Other Paved Roads
Proposed Interstate Highway
Railroads
West Coast Intra-coastal Waterway Canal
County Boundary Line
State Park Boundary Line
Incorporated Areas
Airports
To Bradenton
MANATEE COUNTY
SARASOTA
SARASOTA BAY
LONGBOAT KEY
LIDO KEY
SIESTA KEY
Fruitville Road
Bee Ridge Road
GULF GATE
GULF OF MEXICO
MYAKKA STATE PARK
To Arcadia
SAL R.R.
CASEY KEY
OSCAR SCHERRER STATE PARK
VENICE
Center Road
DE SOTO COUNTY
NORTH PORT CHARLOTTE
CHARLOTTE COUNTY
ENGLEWOOD
MANASOTA KEY
Myakka River
Peace River
To Ft. Myers
41
301
780
72
45
775
776
777
771

NARRATIVE REPORT
SARASOTA COUNTY HEALTH DEPARTMENT
MIGRANT HEALTH PROJECT
May 1, 1967 thru April 30, 1968

I. General Information:

During the twelve months covered by this report, we have seen the completion on one crop season as well as the opening, peaking, and waning of another. There have been no major alterations in the migrant picture in our area. Likewise, the emphasis of our service program has continued virtually unchanged.

Several new developments have taken place this year which will be detailed. These have to do largely with services newly available to the migrant and his family in our area.

During the year, Sarasota County again entertained approximately 2,500 migrants and dependents. Crops grown and harvested in the area consist of celery, cabbage, beans, sweet corn, and tomatoes. Celery is the major product of the area and constitutes approximately one-half of the total production, from a dollar standpoint.

Our objectives for the past year have not altered measurably and continue as follows:

(1) To continue to provide opportunity for state and local public health officials and others to evaluate the program for migrants and to plan for its improvement.

The Statewide Migrant Health Meeting in Miami in November and the East Coast Area Migrant Health Meeting in Orlando in March, both provided valuable guidance, suggestions, and a fresh viewpoint to public health personnel involved in migrant health projects. Both programs were well planned and well presented to be of major assistance to local people toward provision of more effective services.

(2) To implement the basic service program on a statewide basis.

Sarasota County participated fully by providing through clinics and the offices of private physicians and dentists plus cooperation of welfare agencies and hospitals, a wide variety of services including family health clinics (held at night in the migrant housing area), referral for emergent medical and dental care to local physicians and dentists and to the hospital for emergency room and in-hospital care, prenatal, post-partum and family planning service to migrant women, health appraisals. Immunization and day care services to migrant children (infants, toddlers, pre-schoolers, and school-age children) home nursing follow-up and services, tuberculosis, V.D. evaluation of the adults and necessary immunizations for adults plus special referrals through local Crippled Children's, Rehabilitation and Welfare Agencies in the case of specific problems. Basic sanitation has continued to improve, new low-cost housing has been constructed, field sanitation facilities provided and broader scope health education services were getting underway.

(3) To prepare and print fifteen pamphlets in English and ten in Spanish suitable for use with migrants.

To the extent that these health education materials have been made available to us from the state level, we have utilized these items with the migrants. In general, we have found that direct contact and discussion in the person-to-person relationship is the proper manner to educate. No variety of excellent printed material will ever replace personal contact teaching, both at home and at the clinic.

(4) To offer comprehensive medical treatment, including hospitalization. (See #2 above)

A review of the statistical material provided in the accompanying pages will indicate the level and extent of medical care offered through this program. While this county does not have a contract for hospital service, we are aware of a minimum of 25 cases admitted to local hospitals at a cost of approximately $2,500.

(5) To offer specified types of dental care to migrants.

Through our clinic evaluation and public health nurse referral system, 20 cases were referred to private dentists for emergency dental care. For this service the project paid $855 at approved V.A. rates and an additional $500 in unpaid care was donated by the dentists.

(6) To help solve the migrant's problems of transportation.

Since our clinic is so close to the concentration of migrant housing, and since growers and crew leaders have been willing to bring migrants to the clinic when necessary (day haul from downtown areas as well as out-of-town laborers), we have had very little problem with transportation. When such problems did arise, Vista workers, volunteers, and nurses have provided transportation willingly to assure that migrants and services were brought together.

(7) To revise and make use of the referral system.

We have utilized the referral system both within and without Florida and have found it to be most effective in communicating the migrant's needs to other health jurisdictions. In our experience, well over half of the referrals are completed where faithful effort is expended at both ends to identify the needy migrant. Certain additional objectives were added since the inception of the project. They are:

A. To continue to improve the environmental health aspects of the migrant's existance through -

   1. Stricter enforcement of camp regulations. We have one substandard camp which houses about 15 or 20 families. We have tried for 2 years to get it torn down and improved. Progress has been made, but we still do not have a final solution.

The owner will not repair the camp as he is not paid for its use by inhabitants, in most cases. He is willing to have the camp razed, but states that he will not do it, and if we do, we must find housing for the displaced persons. We cannot do this in a housing-short area, so we are at a standoff. Current plans for a church-sponsored low-cost housing area nearby may solve our problem next year as homes would then be available, and we will then burn the whole mess out. Aside from this blight, our camps are up to code. Many migrants now live in the Newtown (Negro slum) area which makes it more difficult for us to locate and serve them. However, they are being assimilated into the community which is our eventual goal, so on balance, I suppose we should be satisfied. We would prefer to get them into decent housing initially rather than to create new slum dwellers. More migrants seem to be settling in Manatee County to the North and working our area by day haul. This also makes follow-up more difficult.

2. Encouragement of growers to provide field sanitation facilities.

This objective was accomplished this year to a degree. The major area grower established a truck-born privy, with the aid of our sanitarian plus comparison with a unit we require contractors to use at the site of new home construction. This unit was placed on the truck and utilized thereon in the fields. Our impression was that most workers appreciated the novelty for a while and then returned to brush-protection disposal. In any event, we will attempt to improve on this next season.

B. To develop, utilize, and revise when advisable, a uniform system of records and forms for all project counties.

This effort was to all effects, abandoned when the new PHS record system was put into service. This is, in essence, a uniform record system which all counties are utilizing. There may be minor variations on how we collect the data, but the resulting record is uniform.

C. To test a procedure for extending health education to migrants and compiling information on the migrant population through the use of liaison workers.

This system was utilized quite effectively last season through our Vista worker. While this was not a liaison worker from the migrant group, as has been attempted elsewhere and recommended, our Vista worker functioned in the same manner. We were very impressed and had requested funds to employ the Vista worker as soon as his Federal relationship terminated, but a family emergency made it mandatory that he leave our area. Two new Vista workers assigned this year have not proved nearly as effective. We had hoped to employ a migrant next budget year to perform such a task, but have been instructed to keep our budget down to this year's level despite increased salaries and other costs. Thus, we will be unable to further test this method of service.

D. To continue to inform the general public and certain groups of the project's aims and the migrant's problems.

These activities have been carried forward effectively. The nurse and sanitarian-health educator developed a series of 35 mm slides which have been utilized widely for community education. Keeping the Medical Society apprised of our program led to the voluntary service of four practitioners (out of 135 who practice in our county) to staff a number of our clinic sessions at no cost. Several community agencies, clubs, and interested groups have been oriented as to the migrant's needs and plans for satisfying them. Our relationships with the local O.E.O. program, whereby migrants are cared for on a regular basis through their mobile clinic facility, has been a significant new development this year.

The objectives noted above have, as indicated, for the most part been achieved. Our primary interest in the next year will be toward improving service rendered, locating migrants who are not aware of our program due to newness to our area and improving follow-up or care rendered. This is ever more difficult due to the fact that migrants are moving into the community and are less accessible thereby.

The composition of our migrant population remains fairly constant. Statistics reproduced as part of this report provide a good cross sectional view of the entire migrant population in the mid-west-coast area of Florida.

Crops produced have remained stable in the area with total acreage under cultivation essentially constant. While we have had a rather severe drought in south Florida for the past two seasons, there has been adequate irrigation water in our area to satisfy the needs so that crops have been nearly average. However, should we not get a break in the situation soon, the cumulative effects of water starvation may begin to show up in crop losses next season.

II. Description of Project Operations:

A. Medical and Dental Services -

The family health service clinic (FAME) is operated one evening every other week during November and December, one evening weekly during January, February, and March, and again every week in April and May. The clinic is held on Tuesday from 6:00 p.m. to 9:00 p.m. and later when necessary. Starting in January this year, the O.E.O. mobile clinic, fully staffed, has operated from the clinic site - (FAME Center) - each Thursday afternoon. This clinic will be present continuously throughout the year, so long as this program continues. This additional clinic service has made follow-up care simpler and has reduced the necessity of referral to local physicians as the full-time clinic physician has treated many of our patients.

Two physicians were utilized at each night clinic this season. A total of 19 clinics were held in the FAME Center while the mobile clinic was present for 12 afternoon sessions. More than 400 different patients made a total of 465 visits to the night clinics while the mobile unit provided service to an additional 30 patients who visited the facility 46 times.

In addition to these regular services, our nurses referred 55 patients to private physicians for care. At least 11 patients were provided emergency service in the hospital emergency room and 25 were known to have been admitted to the hospital. Dentists provided care to 18 patients referred by our nurses.

Members of the staff utilized health education techniques with migrants and their families in both the clinic and the home situation. This consisted primarily of person-to-person discussion of health and sanitation matters during home visits and at the clinic. Other specifics on health education activities are noted in the individual reports.

At each evening clinic session there have been two physicians, a minimum of two public health nurses, one clerk-typist, and the sanitation-health educator. Volunteer help has varied widely but has never been less than two volunteer nurses in addition to health department staff noted above. Many additional volunteers have participated as chauffeurs, translators, blood drawers, screening testers, etc. Except for the use of two physicians at each clinic session, there has been no change made in clinic procedures. All new patients (those upon whom we have no clinic record) are given a physical examination plus height, weight, blood pressure, blood glucose, VDRL, and tine test. They are then treated for any complaints they may have which are amenable to limited treatment through the clinic or referred if they need outside therapy or dental care. Immunizations are also begun and vary depending upon age, immunization status, etc. Children are given all immunizations while everyone gets tetanus as a minimum. Old patients, those for whom we have a clinic record, are treated on the basis of their expressed needs plus the doctor's evaluation. So long as the clinic program meets the migrant's major needs, we see no value in making changes.

While the Sarasota Memorial Hospital Board chose to reject a federally financed hospital program, the hospital does not turn away any patient who is found to need hospitalization. As noted earlier in this report, a number of our patients were admitted and received high quality hospital care at no cost to the project. The hospital refused the hospital component because we are already short of bed space, especially during the tourist season which corresponds to the migrant season. We have four adjacent counties, none of which have hospitalization components and only one of which has a migrant health program. All four entertain migrants during the season. The Hospital Board felt that if they accepted the hospital component, they might be obligated to accept one or more migrants from neighborning counties when the hospital bed status was critical. They felt that they could not accept this responsibility in deference to our own community needs. This thinking is, from our standpoint, fallacious, but they are the elected Board and they set the policy. Our real concern is that we get Sarasota's migrants cared for, and since this has not been a problem, we are not in a strong position to debate the matter. If our migrants were not being accepted, we would have a legitimate complaint, but since they are, we really have no reason to fight.

As mentioned earlier, the O.E.O. has provided a mobile medical clinic for use in Sarasota County to serve the poverty areas. The Fruitville and Newtown areas where virtually all our home base migrants reside both receive service from the clinic. It is located in Newtown two full and and a half days each week and in Fruitville one-half day each week. The clinic is fully equipped and staffed to provide outpatient medical care.

Surgery, obstetrical care, and dental care are not offered therein. The physician, one full-time, one half-time nurse, and two aides staff the clinic. There are facilities for fairly complete laboratory work, but there is no x-ray facility included. Many migrants and their dependents have been served this year both at the FAME Center located in Fruitville, and at the Newtown Community Center. A conservative estimate, based on available statistics, has been provided elsewhere to indicate the volume of service offered. We believe this additional clinic service bears most of the responsibility for the reduction in numbers of patients served at our evening clinics this year. We expect to evaluate this closely next season, and if this proves true, we will transfer the clinic responsibility to the O.E.O. program and phase that portion of our project out in order to reduce project costs and increase local participation.

There have been no notable changes in our relationships with the community; growers; migrants; labor groups; or other local, state, and federal agencies. Primary aid in our program has again come from the churches of the area by virtue of their cooperative actions to solve the day care needs of the migrant children. The church volunteers also redecorated and renovated the clinic prior to the migrant season this year. Utilizing the FAME Center facility, the church women operated a day care center which provided supervision, simple education, snacks and meals plus supervised play to an average of 40 migrant infants, toddlers, and children. This was a very valuable service and also permitted us to do physical examinations on all the children and to complete their immunizations. In planning with the church groups, we foresee an important future for this program. They are in the developmental stage of purchasing several acres of land adjacent to the camps where a day care center, recreational facilities, and a model housing development will be established. This will be for migrants. Low cost homes will be built for forty families with the associated day care center, etc. When completed, this facility will also be used for the FAME Clinic, etc., and the name will be transferred to the new facility. This will relieve the project of rent, utilities, and other expenses. Eventually, probably in two more years, we can phase the project out entirely and continue to provide public health service through the Health Department (including referrals, etc.) while the O.E.O. mobile clinic takes over the outpatient care and the community center provides other services with church and welfare participation. Thus it seems clear that the groundwork has been laid for a better future for a segment of our migrant population plus a phaseout of this project. Once the low-cost housing is established for a small group, we have little doubt that it will expand to provide for all of our migrants who wish to settle in Sarasota County.

Consultation services were provided by Miss Mary Mills of the U. S. Public Health Service who was of great assistance to us. We had also requested consultation in health education to support our sanitation-health educator, but his sudden resignation in April cancelled this need for the present. We hope to fill this position with a health educator before the next migrant season begins. We see no need for future consultation or other services from outside sources at this time.

Until April, there had been no change in our personnel since the project began, thus, we had no orientation or in-service training program for project staff. Now we will need to develop one to provide for the new health educator, when one is found. All new public health nurses who join our staff are oriented to the migrant health service program by the health officer and project public health nurse. Then each is encouraged to work at least one evening clinic session in order to become familiar with the program. Several nurses have enjoyed the clinic so much that they have volunteered to work several evening sessions.

III. Appraisal of Year's Achievements:

The director and members of the staff reviewed the year's activities, and we feel that our basic objectives have been achieved in principal. However, we are all equally certain that there is much which remains to be done before the migrant in our area may be said to have reached the same level of service and community concern as does the usual member of our society.

On the other hand, we note, in working closely with the local O.E.O. programs, that the migrant, in our area at least, has now achieved about equal status with our local poverty stricken families. While this may seem to be an unhappy comparison, one needs only to look back over the short period of about ten years when nearly any migrant would have been pleased to be included in the group of "poor Americans." Today the migrant is recognized as a contributing member of our society. Community people and official agencies are concerned for his well-being and there are organized efforts, which are more or less satisfactory, depending upon the area and the problems, toward providing a more favorable environment, better housing, better standard of living, and adequate community services to which the migrant may turn with expectation of obtaining help. These factors were non existent a short ten years ago and the migrant, as well as the community, may now look forward with real hope toward a series of better tomorrows, and, in time, to first class citizenship along with the masses of deprived citizens of this nation. The migrant has become part of the social conscience of our country and a better future for him is virtually certain.

Presumably there are some problems which cannot be overcome. In our experience, we have found that most so called insurmountable problems result from a lack of knowledge, a lack of technology, a lack of resources, or a lack of desire. In working with migrants and observing their problems, one becomes aware that these four stumbling blocks get pretty confused and that in any given set of circumstances any one or any combination may prevail to prevent the provision of appropriate services or the utilization of services already present. The four factors apply to the provider as well as to those who need the service. Since we have had the knowledge, which in large part is simply recognition that the migrant has unusual handicaps in obtaining community services, and the technology, which largely depends on the use of ingenuity, reasonable intelligence, and the tools at hand, and since we have not been hampered by the lack of desire, which appears to be a serious problem for some, our major problem was lack of resources. Once these were made available thourgh the U. S. Public Health Service grant the outcome was assured. The only remaining question was how soon could we overcome the deficits of such long standing? We still have no answer for that question but a good start has been made and continued effort will result in resolution of the problems. We quickly found that the migrant is rarely a problem, once one accepts the fact that routine service provided according to time honored routines will not adequately accommodate the migrant. It is then simply a matter of tailoring the program to what is feasible for the target group. One learns to work around lack of cooperation, by physicians, to overcome grower hostility, and to beat down active resistance in the rare instances where it is met - the single most distressing problem remains lack of desire on either side. As indicated previously, we have been fortunate in that lack of desire has not been a problem. Other problems and setbacks, such as they were and they were few, have been overcome. Our greatest allies in achieving our objectives have been dedicated personnel, availability of funds to permit good programs through the grant and a community with a great sense of moral values and a community conscience which could not sit idle while others suffered. While I do not necessarily interpret this as a weakness, our greatest dissatisfaction with our current stage of progress is our evident slowness in providing better for all the migrant needs. To date, we have been unable to provide new housing, to convince growers that they must pay a living wage, to assure a proper education to each migrant youth and to assure social justice. These are weaknesses we find all too often in our affluent society, not for migrants alone, but for the very poor in general. These weaknesses must be overcome for all. We hope efforts such as those we are developing through O.E.O., school systems, and in cooperation with churches and the community in general will in the end prevail.

IV. Specific Plans for the Future:

Most of our hopes and plans have already been alluded to - some in depth. So far as the project is concerned, we propose to do a little better next year than we did this year. We have the basic tools; skills, funds; and desire to achieve not only the express project goals, but as much beyond as is humanly possible, within our legal and budgetary framework. We cannot in good conscience do any less.

NURSING

In planning nursing services for our migrant families, we felt that it was essential that nursing care should be available to the migrant patients whenever and wherever they needed it. Since we have only one full-time public health nurse paid from Migrant Health funds, we knew we would have to improvise some new staffing patterns if we were to achieve this goal.

Our project nurse works on a team with two other public health nurses. Through monthly team conferences, they keep each other advised on patient needs in the migrant community and in the areas served by the other two nurses. Since many of our migrant families are now scattered through urban slum areas, these nurses are able to work effectively with them. This nursing team effort allows us to enlist the aid of the other two nurses at peak seasons of the year or for such projects as reading tuberculin skin tests out of the celery fields.

During the summer months when many of our farm laborers are gone, our project nurse is available to assist the other two public health nurses during their busy times.

Our Assistant Nursing Director also serves as supervisor to the migrant nursing services and helps to coordinate nursing and clinic activities. Considerable time was devoted to making the community aware of our migrant clinic and these attempts at better community relations have been of benefit to our project in many ways. Four registered nurses from the hospital and doctors' offices volunteered their time to take turns working our evening clinics throughout the year. Some physicians also assisted in this way, and in addition, many sample drugs were donated to our project.

Our project nurse arranges her working hours so that she is able to see the whole family together at the same time. Frequent evening visits, lunch hour visits, and after-school immunization clinics enable her to work best with each family unit. She takes compensatory time off whenever it fits into the working schedule.

Our part-time migrant secretary also arranges her working time to be able to assist at all evening clinics.

Assistance at the night clinics was also secured by orienting new public health nurses to the clinic to give them experience with lab testing, skin testing, etc.

Our Health Educator-Sanitarian also worked during the night clinics and assisted by weighing patients, and performing various lab and clinic duties.

The migrant nurse visited each camp every day and also regularly talked with crew leaders and growers. New problems and illnesses were discovered at an early stage and many serious medical emergencies were thereby prevented. Sick adults and children were promptly referred to private physicians or to the weekly migrant evening clinic. Since all personnel in the camps and growers offices were contacted by our nurse each week before clinic, most of the sick patients were referred to clinic by either the nurse, the crew leader, or the growers. Nevertheless, the project nurse visited camps during the clinic session to be sure that even the hard-to-reach and reluctant patients were sent into clinic.

> Case History: The nurse visited one cabin at 7:00 p.m. A 14-month-old Negro male was lying on the bed, very still and lethargic, temperature 104°. The child was sent immediately to FAME Clinic with his mother. At the clinic the mother's first request was that she wanted a skin test for her other children. After much questioning, it was discovered that her husband had died of active pulmonary tuberculosis, one month previously, in Alabama. Since we had no prior knowledge of this and no follow-up had been done on the family, we began an intensive study of this family. Little James was admitted to our local hospital for treatment and is at present hospitalized at W. T. Edwards Tuberculosis Hospital. The mother, who was also eight months pregnant, and two other children were started on prophylactic TB medication.

In addition to ursing all patients to attend clinics if needed, the project nurse spent much time persuading families to take advantage of the child care facilities located at FAME Center. All children are encouraged to attend regardless of financial circumstances. Still, some parents can not be persuaded, and tradegy may result.

Case History: The nurse visited a home and found preschool children playing alone while the parents were out working. She made an evening visit to ask these parents to take the children to the child care center during the day. The parents did not make the effort, however, and three days later their house caught fire. The two-year-old girl was seriously burned and expired four days later. If she had not been left in the care of her five-year-old sister, this tragedy would not have occurred. At least, it is to be hoped that knowledge of this accident will encourage other parents to bring children to the child care center.

While the day care center was in operation, the nurse was on call for any emergency. She also made a daily visit to the center to pick up health problems early.

Dental screening was another service offered to our migrants this season. The migrant dental hygienist came to our clinic and also did dental inspections in the camps at night.

Health education was a vital and integral part of our nursing service. Educational efforts involved each patient and family, as well as community leaders, church groups, and our own health department staff (in the form of in-service education to all departments).

Case History: About the middle of the season we had an outbreak of diarrhea in our Mexican crew. Five children were hospitalized with diarrhea and dehydration. Stool cultures showed salmonella and shigella. Water was tested and found satisfactory and an investigation was begun to find carriers in the camp. Stool specimens were sent on all families in the camp. Several positive cultures returned from apparently healthy individuals.

Since the only sink in each household was used for diapers, dishes, cooking, and handwashing, we decided that only an all-out effort of health education could stop this epidemic. A local private hospital donated colorful plastic hand basins for each family. An evening health education program was conducted in the camp to demonstrate proper handwashing technique. Each family was given a pastel basin and some antiseptic solution and instructed to wash their hands in it after diapering babies or using the bathroom.

Accident prevention was always uppermost in the nurse's mind as she visited homes. The biggest problems were old unused refrigerators and broken glass. Good cooperation was secured by showing these hazards to crew leaders and camp members and explaining each time how they could cause harm.

Our migrant nursing services depend to a very large degree upon the cooperation of community agencies, church groups, private physicians, and local pharmacists. Therefore, every effort is made to keep up good community relationships. When referrals are made to private physicians, migrant referral blanks are used and all available information is included. The migrant nurse frequently calls physician's offices to report on home conditions or to relate follow-up treatment that has been given to his patients. Physicians appreciate having this information and continue to cooperate with us.

Referrals to private physicians always include arrangements by the nurse for transportation. This has lowered the number of broken appointments, and volunteers have been most helpful in providing transportation.

Physicians are also more anxious to treat patients if they know that out-of-state follow-up will continue, so we try to see that all patients have complete referrals sent to their next location. We have stressed the importance of the individual personal health record this year. In this way, if a migrant does not settle down where his referral has been sent, at least the migrant may seek help himself in his new location. Migrant awareness of health facilities seems to be increasing.

Our plans for the future include the possible employment of a health aide from the migrant community. And we think we have the right person in mind for the position. Our project nurse and the young migrant woman participated in the Migrant Health Inter-Intra-State Referral Conference in Washington, D.C., this spring. She was able to explain the needs of the migrant to other conference participants and we feel that she would be a valuable addition to our team.

Nursing personnel also plan to work closely with the community organization that is hoping to build a new day care center. Such a center would be of great benefit to our migrant families. The same group also plans a low-cost housing unit in the future, and, of course, we are doing our best to encourage this. Living conditions and the general health of our migrant population would be greatly improved by these developments. Having seen the wonderful cooperation between our community and our migrant staff, in the past, we have great hopes for the future.

SANITATION

Although there was only one full-time sanitarian on the Migrant Health Project, much was accomplished this year by working through interested church and civic groups to bring out improvements in sanitation. A Vista volunteer was an invaluable asset to our team, as he lived with the migrants and helped them to understand the need for cleanliness in their surroundings.

The sanitarian's two main objectives were:

(1) To see that all camps were permitted in accordance with Chapter 170C-32 of the Florida State Sanitary Code. If any camp failed to meet these requirements, it was closed as soon as possible.

(2) To continually meet with crew leaders, growers, and local community groups explaining our program and objectives.

Many things were accomplished this year, but much still remains as a challenge for the future. Our biggest problem will always be Johnson's camp. As long as it exists, there will be work to be done. Low-cost housing is just not available at the present time. As long as there is a housing shortage, families will have to live in Johnson's camp.

With the exception of Johnson's Camp, the proportion of work accomplished has been high. A summary follows:

(1) Garbage and Trash Disposal: All labor camps in Sarasota County now have twice-weekly garbage and trash collections. This has been a great help in obtaining better sanitary conditions at each camp.

(2) Water Supply: As stated in previous reports, potable water is not a problem in Sarasota County. Periodic checks are made and the water has proven to be bacteriologically satisfactory. Here again, Johnson's Camp has been the exception, but after numerous unsatisfactory reports, this department was able to get a hypochlorinator installed at Johnson's Camp.

(3) Rodent and Rabies Control: Both rodent and rabies control programs are in existance during the period when each camp is occupied. This year, as opposed to last year, no rodent or dog bites occurred.

(4) Sewage Disposal: Johnson's Camp still uses insanitary pit privies. However, all other camps have either chemical toilets or central toilet facilities. We are in hopes of obtaining some chemical toilets in Johnson's Camp.

(5) Miscellaneous: In general, most of our goals have been reached through the cooperation of our growers and crew leaders. With regular maintenance of screens and windows and painting when necessary, our camps are in very good shape.

Our relationship with growers, crew leaders, and migrants continues to be good. With the migrants we have utilized the approach that they must help themselves as the growers extend better services to them. In other words, if they enter a clean camp, they should keep it that way.

Working with the Farmer's Home Administration, we have finally seen the completion of two homes within the Fruitville Area. These homes represent only a small start toward what we hope will become a major housing development in this area. More frequent consultation from F.H.A. and other government housing projects would be helpful.

Our three major camps are of cement block construction with metal roofs. The one exception is Johnson's Camp, which is of wood. In general, the conditions are good, in spite of some overcrowding. Trends in migrant housing point to a definite need for more single-family dwellings.

Our authority for issuing permits is found in Chapter 170C-32, Florida State Sanitary Code. The sanitarian makes regular inspections to insure that standards are met at all times.

Housing conditions have improved as a result of two main factors:

(1) Growers and camp owners have been encouraged to employ a maintenance man or make the crew leader responsible to see that housing conditions are continuously improved.

(2) Migrants themselves have been shown individually the importance of keeping their living quarters clean.

An analysis of Table B has already been given above in discussing proportion of work accompliahed.

Field sanitation and work environment have imporved to some extent, but we still have a long way to go in this area. Crews are given a 15-minute break in the morning and one in the afternoon. This is in addition to normal lunch break. Local merchants sell soft drinks and sandwiches to migrants during their lunch period.

One grower has created a portable semi-chemical toilet which is transported around the field as the migrants work. This portable toilet is emptied every evening. In other fields, sanitation facilities are not good and improvements must be made.

Health education has been a main point in all of our sanitarian's work. It will be discussed more fully under Health Education.

As previously stated, we feel that as soon as Johnson's Camp can be eliminated and adequate housing built, we will have met our major objectives.

Cement block buildings, routine garbage collection, chemical or interior toilet facilities and portable water meet most of our immediate objectives, however.

We feel that our accomplishments have come primarily from working as a team. Our nurse and sanitarian make visits together and point out safety hazards and insanitary conditions. If a child is sick and we can show the parents that poor sanitary conditions may have contributed, usually this motivates the parent or landlord to correct the condition. Also, we have spent much time making the growers and crew leaders aware of our services and they are quick to seek help. Camp owners and growers are becoming increasingly aware of the fact that comfortably housed, healthy workers can do a better job for them. Therefore, they find it is good business for them to comply with our requests and suggestions.

Our plans for the futrue are indefinite at present, due to the vacancy of one project position. If a good health educator cannot be found, possibly a sanitation aide could complete our staff. In any case, we plan to continue our present program with help of regular sanitation staff from the health department.

HEALTH EDUCATION

Since a professional health educator has not been part of our staff, all project personnel; public health nurse, sanitarian, and clerk-typist, functioned as health educators. Many educational programs were also presented to volunteer church groups and these people in turn helped us educate the migrants.

Our health education program had three main objectives:

(1) To convince each migrant that better nutrition, better health habits, and cleaner homes would mean less sickness for themselves and their families. Less sickness means more money for the family.

(2) To help the grower understand that better environmental conditions at each camp mean more productivity per man hour and that migrants are willing to upgrade themselves if they know the growers are willing to help.

(3) To keep the community advised regarding the problems of the migrant.

We have found that educational efforts directed toward the community have paid us big dividends in volunteer helpers. We could not continue to provide for our migrants the kind of program we want them to have, if it were not for our volunteer workers. Volunteer physicians and registered nurses have assisted in clinics; church workers have renovated buildings; physicians have donated sample medications; school personnel have conducted tutoring sessions; community volunteers have staffed the child care center and furnished transportation for migrants' medical appointments. Because we consider community education such an important part of our work, a series of color slides has been prepared for showing to church and civic groups.

Our health education program needs consultation as to where to find or how to develop new materials for teaching migrants on their level. We especially need films on venereal disease, care of babies, birth control, general sanitation, and health habits. We have proven, at least to ourselves, that with proper colored slides we can tell the migrant story to just about anyone. Now we need slides to explain our story to the migrants.

Some of the main topics covered in either individual or group teaching of migrants were:

(1) Care of babies; feeding, bathing, proper diapering procedures.

(2) Need for immunizations for all members of the family and the necessity of keeping a written copy of this and other health records.

(3) Cleanliness in the preparation of food.

(4) Family planning.

(5) Good health habits and cleanliness.

Though we have used some films, the group of colored slides which we have prepared over the last two years has proven most helpful to us in working with our community. These slides were all taken in Sarasota County and tell the migrant story in realistic detail. They can be shown by any member of our project staff and can be shown to growers, civic or church groups, or interested community groups. Our wonderful community support has undoubtedly come about through community education. Our entire staff places a high priority on this type of health education. Its value to our project has been clearly shown.

We believe that our health education program is having a beneficial effect, because we see so much interest on the part of the migrants. They recognize health problems early and come to us for help. They ask questions, so we know their interest has been aroused. Many more women are asking for planned parenthood services. This we thought we would never see, especially in our Spanish groups.

Our major problem in health education has been communication with Spanish-speaking migrants. We have been fortunate in finding volunteers to translate for us, but our program would be much more effective if at least one project member could speak Spanish.

Our future plans call for a continuation of our present health education program by all project personnel. Due to the vacancy at present of one of our project positions, we are looking for a health educator. If this position can be filled, we expect to make even greater strides in the field of health education. We will continue to work to improve relationships with migrants, crew leaders, growers, and interested community groups. The health of the migrant workers is everyone's problem and we look to the community for help.

The following services were performed by the sanitarian-health educator in the past year to produce the results stated in the previous sanitation and health education narratives:

(1) Meetings attended as spectator and participant	39
(2) Talks made	5
(3) Conferences	79
(4) Programs Using Audio-Visual Aids	1
(5) Exhibits Prepared	35

NUTRITION SERVICES

Regular planned nutrition services for the migrant were initiated this year as the nutrition coordinator for the Migrant Health Project was hired in February and began to participate in clinics at the FAME Center. During these clinics the nutritionist discussed with the parents the foods they should serve their families daily, and how to economically procure them. Work has also started with the migrant day care center in assisting the staff in planning and serving culturally acceptable, nutritious meals and in building a strong nutrition education component into the day care center program.

The nutrition program plan for the coming year will include:

(1) Diet counseling for all prenatal cases seen in clinic.

(2) Diet counseling for any patient whom the clinic physician feels will profit by it.

(3) Food demonstrations of culturally acceptable, nutritious foods; both in the camps and at clinics.

(4) Nutrition education for all migrant children at the day care center and in the public schools.

(5) Preparation of a nutrition education slide-tape series on basic nutrition, prenatal nutrition, and infant and pre-school nutrition.

(6) Preparation of realistic pamphlet materials on nutrition, both in Spanish and English.

(7) Constant evaluation of nutrition services by:

    a. Measuring the effect of clinic counseling

    b. Assessing any changes in nutritional status of the migrant children by measurement and teacher and nutritionist observations.

    c. Measuring the value of food demonstrations by observing what food habits are changed.

SEMINOLE COUNTY HEALTH DEPARTMENT

Frank Leone, M. D., Director

Area of County:	352 square miles
Resident Population:	67,500
Migrant Health Project Staff:	3 Public Health Nurses 1 Sanitarian 1 Clerk-Typist

PRETEST DRAFT - 1967

MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT

For May 1, 1967 through April 30, 1968

Date submitted May 13, 1968

PART I - GENERAL PROJECT INFORMATION

1. Project Title

A Program to Develop a Statewide Program of Health Services for Migrant Farm Workers and Their Dependents in Florida.

2. Grant Number (use number shown on approved application)

PROJECT MG 18E (68)

3. Name and Address of Applicant Organization

SEMINOLE COUNTY HEALTH DEPARTMENT
P. O. BOX 1856
SANFORD, FLORIDA 32771

4. Project Director

FRANK LEONE, M.D.

5. Population Data - Number of Migrants (workers & dependents) for SEMINOLE County:

a. Number of migrants during season:

	Total	Male	Female
1. Out-migrants			
Total	12,500	6067	6433
Under 1 year	369	172	197
1 - 4 years	1,477	781	696
5 - 14 years	3,045	1496	1549
15 - 44 years	4,306	2062	2244
45 - 64 years	2,320	1109	1211
65 and older	983	447	536
2. In-migrants			
Total	600	331	269
Under 1 year	18	8	10
1 - 4 years	74	40	34
5 - 14 years	152	75	77
15 - 44 years	240	187	53
45 - 64 years	116	91	25
65 and older	-0	-0	0

b. Number of migrants by month:

Month	Total	Month	Total
Jan.	11,960	Jul.	6,650
Feb.	15,350	Aug.	6,125
Mar.	9,150	Sep.	6,340
Apr.	8,725	Oct.	9,300
May	7,650	Nov.	11,740
June	7,000	Dec.	12,500

c. Average stay of migrants in county:

Out-migrants: 34 weeks

from October (mo.) through May (mo.)

In-Migrants: 17 weeks

from January (mo.) through April (mo.)

d. Source of information and/or basis of estimates:

Seminole County Agriculture Bureau
U.S. Department of Commerce, Characteristic of the Population, Seminole County

6. Housing accommodations for SEMINOLE County:

a. Camps One

Maximum Capacity	Number	Occupancy(peak)
Less than 10 persons		
10 - 25 persons		
26 - 50 persons		
51 - 100 persons		
More than 100 persons	1	120

b. Other housing accommodations Many

Type	Number	Occupancy(peak)
Farms	0	0
Other locations		
Rooming Houses	50	1,500
	Most of	our Migrants live in
	Houses	rented or owned
Homes	2,200	11,000

c. Append map showing location of camps, roads, clinics, and other places important to project.

PRETEST DRAFT - 1967

Project No. MG-18E (68)
Date submitted May 13, 1968

Seminole County

PART II - MEDICAL, HOSPITAL AND DENTAL SERVICES

1. Patients receiving outpatient medical services:Family Health Clinics & E.R.

Age	Number of patients			Number of Visits
	Total	Male	Female	
Total	1044	424	620	1577
Under 1 year	85	47	38	119
1 - 4 years	215	110	105	235
5 - 14 years	241	122	119	309
15 - 44 years	374	113	261	644
45 - 64 years	120	26	94	250
65 and older	9	6	3	20

2. Patients hospitalized:

Age	Number of patients			Hosp. Days
	Total	Male	Female	
Total	22	11	11	535
Under 1 year	3	2	1	30
1 - 4 years	3	2	1	43
5 - 14 years	0	0	0	0
15 - 44 years	12	6	6	45
45 - 64 years	4	1	3	417
65 and older	0	0	0	0

The total hospital patients includes patients now in the hospital, total days are incomplete, 2 T.B. cases includ too

3. Patients receiving dental services:

Item	Total	Under 15	15 and Older
a. Number of migrants examined: total	91	23	68
Number of decayed, missing, filled teeth			
Average DMF per person			
b. Individuals requiring services: total	91	23	68
Cases completed	91	23	68
Cases partially completed	0	0	0
Cases not started	0	0	0
c. Services provided: total	318	39	279
Preventive	0	0	0
Corrective	17	6	11
Extraction	280	29	251
Other	21	4	17
d. Patient visits: total	171	29	142

4. Immunizations provided:

Type	Incomplete series	Completed immunizations - by age					Boosters, revaccinations
		Total	Under 1 year	1 - 4	5 - 14	15 and older	
All types	74	740	88	124	295	97	136
Smallpox	13	91	0	30	42	0	19
Diptheria	11	111	21	13	62	0	15
Pertussis	15	90	21	13	41	0	15
Tetanus	11	87	21	13	21	10	22
Polio	14	142	25	33	46	0	38
Typhoid	10	65	0	10	38	0	17
Measles	0	57	0	12	45	0	0
Other (specify)							
FLU SHOTS		97				87	10

SEMINOLE COUNTY

5. Medical conditions found by physicians among outpatients, by age of patient:

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
I	Infective and parasitic dis.	297	14	96	76	96	5	
	a. Tuberculosis	2	0	0	0	2	0	0
	b. Venereal Disease	84	0	0	2	68	14	0
	c. Measles							
	d. Infestation with worms	129	11	74	44	0	0	0
	e. Dermatophytosis & other infections of skin	82	3	22	30	26	1	0
	f. Other							
II	Neoplasms	2					2	
	Malignant	1	0	0	0	0	1	0
	Benign & unspecified	1	0	0	0	0	1	0
III	Allergic, endocrine, metabolic, and nutritional dis.	67	4	21	5	23	14	
	a. Diabetes	11	0	0	0	3	8	0
	b. Malnutrition	31	4	17	2	6	2	0
	c. Other	25	0	4	3	14	4	0
IV	Dis. of blood and blood-forming organs	27	1	6	7	11	2	
	Anemias	27	1	6	7	11	2	0
	Other							
V	Mental, psychoneurotic and personality disorders	23	0	0	1	16	6	0
VI	Dis. of nervous system and sense organs	205	27	66	66	32	14	
	a. Cerebro-vascular disease (stroke)	3	0	0	0	0	3	0
	b. Eye Diseases	66	0	13	34	12	7	0
	c. Dis. ear and mastoid pro.	118	27	52	22	14	3	0
	d. Other dis. of nervous system	18	0	1	10	6	1	0
VII	Dis. of circulatory system	140				49	87	4
	Rheumatic fever	8	0	0	0	5	3	0
	Diseases of the heart	20	0	0	0	1	19	0
	Hypertension & other dis. circulatory system	112	0	0	0	43	65	4
VIII	Dis. of respiratory system	525	77	140	118	152	34	4
	a. Upper respiratory	448	68	119	101	129	29	2
	b. Influenza and pneumonia	25	6	11	5	3	0	0
	c. Bronchitis	13	3	2	3	3	2	0
	d. Other	39	0	8	9	17	3	2

5. Medical conditions found by physicians among outpatients, by age of patient (cont'd.):

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
IX	Digestive system diseases	104	15	15	33	29	12	
	a. Teeth and supporting structures	30	0	2	16	9	3	0
	b. Gastroenteritis, colitis	42	7	5	14	11	5	0
	c. Other	32	8	8	3	9	4	0
X	Dis. of genito-urinary system	80		2	16	45	9	8
	Urinary system diseases	49	0	2	16	14	9	8
	Genital system diseases	31	0	0	0	31	0	0
XI	Deliveries and complications of pregnancy							
	Complications of pregnancy							
	Deliveries							
	Compli. of puerperium							
XII	Skin diseases	124	9	33	48	27	5	2
	a. Impetigo	49	5	21	18	5	0	0
	b. Other	75	4	12	30	22	5	2
XIII	Dis. of bones and organs of movement	20	0	2	3	4	10	1
XIV	Congenital malformations	2	0	0	1	1	0	0
XV	Dis. of early infancy	2	0	1	1	0	0	0
XVI	Symptoms, ill-defined cond.	60	2	1	10	30	17	0
XVII	Accidents, poisonings, violence	84	0	10	33	26	15	0
	TOTAL OF CATEGORIES I-XVII	1,762	149	393	418	541	242	19
SUPP	Special conditions, examinations, w/o sickness: total							
	Prenatal, postnatal care	22	0	0	0	22	0	0
	Physical examinations	6	0	0	0	5	1	0
	Immunizations							
	Surgical or medical after-care, follow-up	12	0	5	3	0	4	0
	Fitting prosthetic devices							
	Other	14	1	1	4	0	8	0
	Planned Parenthood	54				54		

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Seminole County

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SEMINOLE COUNTY

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	b. Malnutrition	31	4	17	2	6	2	0
	c. Other	25	0	4	3	14	4	0
IV	Dis. of blood and blood-forming organs	27	1	6	7	11	2	
	Anemias	27	1	6	7	11	2	0
	Other							
V	Mental, psychoneurotic and personality disorders	23	0	0	1	16	6	0
VI	Dis. of nervous system and sense organs	205	27	66	66	32	14	
	a. Cerebro-vascular disease (stroke)	3	0	0	0	0	3	0
	b. Eye Diseases	66	0	13	34	12	7	0
	c. Dis. ear and mastoid pro.	118	27	52	22	14	3	0
	d. Other dis. of nervous system	18	0	1	10	6	1	0
VII	Dis. of circulatory system	140				49	87	4
	Rheumatic fever	8	0	0	0	5	3	0
	Diseases of the heart	20	0	0	0	1	19	0
	Hypertension & other dis. circulatory system	112	0	0	0	43	65	4
VIII	Dis. of respiratory system	525	77	140	118	152	34	4
	a. Upper respiratory	448	68	119	101	129	29	2
	b. Influenza and pneumonia	25	6	11	5	3	0	0
	c. Bronchitis	13	3	2	3	3	2	0
	d. Other	39	0	8	9	17	3	2

SEMINOLE COUNTY

5. Medical conditions found by physicians among outpatients, by age of patient (cont'd.):

ICD Class	Diagnosis or Condition	Total	AGE OF PATIENT					
			Under 1 year	1 - 4	5 - 14	15 - 44	45 - 64	65 & Older
IX	Digestive system diseases	104	15	15	33	29	12	
	a. Teeth and supporting structures	30	0	2	16	9	3	0
	b. Gastroenteritis, colitis	42	7	5	14	11	5	0
	c. Other	32	8	8	3	9	4	0
X	Dis. of genito-urinary system	80		2	16	45	9	8
	Urinary system diseases	49	0	2	16	14	9	8
	Genital system diseases	31	0	0	0	31	0	0
XI	Deliveries and complications of pregnancy							
	Complications of pregnancy							
	Deliveries							
	Compli. of puerperium							
XII	Skin diseases	124	9	33	48	27	5	2
	a. Impetigo	49	5	21	18	5	0	0
	b. Other	75	4	12	30	22	5	2
XIII	Dis. of bones and organs of movement	20	0	2	3	4	10	1
XIV	Congenital malformations	2	0	0	1	1	0	0
XV	Dis. of early infancy	2	0	1	1	0	0	0
XVI	Symptoms, ill-defined cond.	60	2	1	10	30	17	0
XVII	Accidents, poisonings, violence	84	0	10	33	26	15	0
	TOTAL OF CATEGORIES I-XVII	1,762	149	393	418	541	242	19
SUPP	Special conditions, examinations, w/o sickness: total							
	Prenatal, postnatal care	22	0	0	0	22	0	0
	Physical examinations	6	0	0	0	5	1	0
	Immunizations							
	Surgical or medical after-care, follow-up	12	0	5	3	0	4	0
	Fitting prosthetic devices							
	Other	14	1	1	4	0	8	0
	Planned Parenthood	54				54		

PRETEST DRAFT - 1967
Project No. MG-18E (68)
Date submitted May 13, 1968

SEMINOLE COUNTY

PART III - NURSING AND SANITATION SERVICES

1. Nursing services (field nursing)	Number
a. Visits to homes	1,023
b. Total households served	492
c. Visits to schools, day care centers: total	115
d. Migrants presenting health record on request (PHS 3652)	3
e. Migrants given health record	20
b1. Total No. Indiv. Served	1,481

Services provided:	Number
f. Health supervision, counselling, teaching, demonstrating care ~~in homes~~	737
g. "Sick call" (nursing clinics)	96
h. Referrals for medical or dental care: total	
Within area: total	206
Number completed	201
Out of area: total	6
Number completed	6
i. Other (specify)	
Hospital Verifications	24

2. Sanitation services

Table A. Survey of housing accommodations of migrants

Housing Accommodations	Total number	Number with Permits	Housing Units			Dormitories		
			Total number	Covered by permits		Total number	Covered by permits	
				Number	Maximum capacity		Number	Maximum capacity
Camps	1	0						
Urban or other locations			2,200	0	16,000	50		1,500

Table B. Inspection of living and working environment of migrants

	Number of locations inspected*	Total number of inspections	Number of defects found	Number of corrections made
Living environment				
a. Water	66	86	46	40
b. Sewage	88	160	80	80
c. Garbage and refuse	100	155	70	70
d. Housing	308	500	165	105
e. Safety	9	26	5	5
f. Food handling	52	208	0	0
g Insects and rodents	26	48	19	10
h. Recreational facilities	14	38	4	4
Working environment				
a. Water	31	90	11	7
b. Toilet facilities	24	72	18	15
c. Other Packing houses Processing Plants	12	28	4	4

* Locations - camps or other locations where migrants work or are housed

ANNUAL PROGRESS REPORT
SEMINOLE COUNTY
Period Covered - May 1, 1967, thru April 30, 1968

PART IV. NARRATIVE FOR ANNUAL PROGRESS REPORT

I. General Information

A. This is our second annual progress report, covering the period from May 1, 1967, through April 30, 1968.

Seminole County is located in East Central Florida and has a population of 83,000 residents within its 352 square miles. The migrant population is estimated at 12,500 - 98 per cent Negro and 2 per cent Anglo. Agriculture is the main source of income and principal activity of the county. Seminole County ranks fourth in Florida in the value of vegetables for sale.

Agriculture plus its related activities, such as food processing and servicing, is the largest single employer. Seminole is the fourth smallest county in the state in land area; 21,969 acres, 9.5 per cent is given over to citrus and 6,313 acres (29 per cent) to vegetables. In Seminole County, 100 per cent of the vegetable farms and 23 per cent of the citrus groves use supplemental water as irrigation. Some farmers use a portable sprinkler system which improves yields during dry periods.

Heavy urban growth, particularly in the southern section, described as the fastest growing urban area in the nation, has caused a great shift in citrus production but has not yet cut too deeply into the volume. The on tree value is over 7.6 million with an agri-business value equal to 12.5 million. Citrus is the leading agricultural commodity. It is by far the largest contributor to a total agricultural industry which brought some 17 million dollars to the growers and generated some 32 million through allied business. Citrus is presently found in every township in the county. Remaining groves in the southwestern portion of the county are facing extinction from the continued urban build-up.

Although mechanical harvesting of citrus crops is in the offing - at least for processed fruit - the industry will be looking to the individual fruit picker for some years to harvest the golden crop. The concept of what constitutes a practical harvester has been revised many times. Devices for harvesting the fruit off the trees have not proved practical as yet. The manual fruit picker still carries the main load while citrus men dream of the perfect mechanical picker. Seminole County is now growing peaches, the Floridawon, and experimenting with other varities. Drought appeared to plague crops and groves to some extent which were desperately in need of rain. The drought took its toll of some vegetable growth. Fruit was smaller and matured late. Millions depend on the labor of farmworkers from outside the local area during the peak harvest season.

B. The goals of the migrant health program are to raise the health status of migratory farm workers and their families: by providing comprehensive health services with continuity, by extending community services to migratory families wherever they are at places and under conditions which make the services easily accessible and thus readily used, by improving the migrants environment to assure them of healthful, safe living and working conditions.

C. There has been no change in our objectives except to emphasize continuity of care through more and better use of the referral system, and to motivate the migrant to self-help. Continuity of care becomes more possible as project services are provided along the migrant route. Personal health records carried by these people facilitate continuity and help to avoid gaps in services. Lack of continuity of health care will remain a problem as long as many communities have no place to which a migrant can go for needed health care. For the migrant to attain the health status comparable to the general population, there must be an increase in projects as well as expansion of services. This can only be done with additional funds. The per capita health expenditure for migrants isfar below that of the national average.

Some necessary goals in all this must be to help the migrant help himself, establish continuity of care as they move from place to place, and very important, to do something about the much neglected health education. This latter cannot be done merely by the project staff as time and workload do not permit a thorough nor efficient program. It must be an organized consultative affair. It is a broad field and needs improvement both in quality and quantity. This is the domain of the health educator. The migrant must be taught to assume more responsibility to meet their health problems, something they are not only not aware of, but rarely assumed responsibility for in the past. To increase and improve the use of the referral system and also to promote the use of the personal health record will accomplish much.

D. There is little variation in the type of migrant from last year.

1. Most of our farm workers live in Seminole County and either rent or own the house in which they live. As such, they have, to some extent, become part of community life through their own activity. Their age and sex composition varies little. Many remain in Seminole, where they live, others travel further south for awhile and the majority follow the season north in June, July and August. A goodly number of in-migrants are seen during the peak season from Manuary through March, mostly males, who then leave to go further south or north.

2. The economic situation in Seminole County is quite stable. We experienced less unemployment this season than any year in the past. We had a good and profitable harvest with several plantings in cabbage, celery, carrots, beans, etc. Market conditions brought good prices due to rather favorable weather. The vegetable crop yield was very good in spite of the drought. Citrus was not as plentiful as the 1966-67 season. So far, few machines have been invented to replace human beings in orchards, groves, or on the farm at harvest time. Until more such machines are invented, the cultivation and harvest of much of the farm crop in Seminole will depend on the availability of migratory workers. The celery harvest is

80 per cent mechanized. The other crops are manually harvested. However, anyone wanting to be realistic about the situation, must agree that higher wages are going to force growers toward greater efficiency and automated (mechanization) systems of one form or another in order to survive. They also face some problems with the machine themselves. Even should a grower want to mechanize more completely, he may not be able to because of the lack of commercially available equipment that is tried and tested and ready to do the job.

3. There were no extreme weather changes to cause any disruption in the labor situation. Citrus did mature rather late due to a period of drought. Migrants have less access to health care than other members of our population, although they generally have a greated need for same. The migrant families transient way of life aggravates the many basic health problems which are associated with their poverty and poor living conditions and working conditions.

II. General Description of Project Operations During Year

A. Medical and Dental Services.

1. At present a good beginning has been made but we still have parts of the county that need more organized services. One large neglected area, namely Monroe, with approximately 3,000 migrants, is in bad need of health services. Transportation to other clinics is difficult and distant as well as costing money. The migrant project staff as well as the health department personnel are offering as many services as possible. We have a migrant clinic in Midway, in the center of a very large farm and citrus area. The Midway clinic schedule is:

Midway Clinic (Day)		Midway Clinic (Evening)	
Monday	8 - 11 a.m.	Tuesday	7 - 9:30 p.m.
Thursday	8 - 11 a.m.	Thursday	7 - 9:30 p.m.
Friday	1 - 3 p.m.		

There is another migrant clinic sixteen miles away in Oviedo with many large farms and citrus groves nearby. The Oviedo clinic schedule is:

Oviedo Clinic (Day)		Oviedo Clinic (Evening)	
Tuesday	1 - 4 p.m.	Monday	7 - 9:30 p.m.
Thursday	9 - 11 a.m.		

2. Through the maternity-infant care program, we are able to send maternity cases for dental attention on a fee-for-service basis, thus relieving the burden on our dental budget to allow for the acute care of children. We have also arranged with several dentists in the south end of the county to render services in emergency cases for gratis.

3. There is a dire need to expand dental and health services. We hope that this will be accomplished now that we have made arrangements with several dentists to visit our schools to lecture and demonstrate dental health practices. We have also made arrangements with a nearby hospital

to accept maternity cases for a nominal fee to include delivery and several days hospital confinement which is working out very well.

4. There were not many referrals, but practically all local referrals were completed with satisfactory results. When it becomes necessary for the family to migrate before the services are completed, the patient is referred whenever possible to the health department in the area to which they moved, in order to insure continuity of care.

5. There are four physicians who rotate their services in the evening sessions both in the Midway facility and in the Oviedo clinic. The health department dentist takes care of the indigent children primarily. Several dentists service the migrant children with acute conditions and urgent adult cases, as well as acute oral problems in the prenatal females. Four dentists in the south end of the county give their services gratis to indigent and migrant children with acute conditions. Migrant Health Project nurses attend day clinics, assist physicians in evening clinics, and also the pediatrician attending the well-baby clinic. The health department nurses help with home visits to mother and child because of the heavy load carried by the project staff. The V.D. epidemiologist often attends night clinics taking serologies. Selected local migrants and volunteers trained by us as health aides help with babysitting, with transportation and communication. They also act as intermediary persons who are quite effective in bringing about change in health practices among their own. They also assist in the utilization of existing programs. Contributions from other sources, especially the health department, include equipment, facilities, tuberculosis and psychiatric services, and other items essential to project operation. Through the Community Action Agency (The Economic Opportunity Act) we are trying to get as many migrant children as possible into day care centers where they would be safely supervised, receive better health protection, and learn. In several instances, because of these trained migrants, very sick children (babies) were brought to the clinic and quickly hospitalized with pneumonia; thereby, I am sure, saving their lives. These aides or community migrants were able to contact many of the unreached, successfully communicate with their own and see that they came to the clinics for dental and medical attention.

6. Use of available services is usually a good measure of the effectiveness of a public health program. This past year there has been a high degree of acceptance among low-income (migrant) families. Another migrant clinic was opened in Oviedo in the south end of the county in the midst of a large migrant farm and citrus area, where approximately three thousand migrants are located. Additional and better consultative resources were utilized; namely, for tuberculosis and a psychiatrist for mental disturbances, plus expansion of nutritional services with more and personel instruction. A clinic for insertion of intrauterine devices was initiated and added to our family planning services. Cancer screening and glaucoma screening and well-baby clinics are now held in all units. Three times as many women are registering early in their pregnancies. All expectant mothers are given complete physical and dental examinations. Routine laboratory work includes serology, determination of Rh factor, hemoglobin, urinalysis, pap smear, glucose tolerance test, tuberculin test, and check for worms. Consultation with

a nutritionist is specified for mothers with kidney disease, diabetes, malnutrition, or obesity. Iron deficiency anemia has been found to be the most prevalent risk condition. Special arrangements have been made with a hospital to allow these expectant mothers to deliver and stay for two days at a reduced fee.

7. There is a dire need to expand dental and health education services. More financial help is necessary in order to provide adequate coverage for the migrant and his family. Another clinic for a large migrant population in the north end of the county is absolutely essential if we are to render total and efficient protective care. This one is a long distance from any present clinic and transportation is non-existent. We need to put our services where the need is - out where these people live and work. Programs for health care of the disadvantaged should be given the highest priority. At the same time, an effort should be made to develop and use the talents of those who live in poverty areas in helping to meet their own problems. A kind of self-help one might say.

   If we add up the problems of money, strenuous work, overcrowded housing and poor sanitation; plus lack of medical care and facilities, we are bound to find ourselves confronted with a health problem. Tuberculosis is higher among this group than it is in the general population. Migrant children and adults show a greater percentage of positive reactors to the tuberculin test. Despite the high rate of infection, when active cases are found, isolation is nearly impossible and hospital care is difficult to arrange. If the father has tuberculosis, what happens to the family? This may leave the family without means of livelihood in an area where they are non-resident and therefore cannot qualify for aid. There should be some arrangement to facilitate hospitalization for tuberculous migrants with no residential status.

B. Hospital care for seriously ill or injured persons is now arranged and paid for. Migrant crew leaders and farmers have been informed about the services available. Expanding the scope of services to include patient care in the hospital has helped us meet many previously frustrating problems. Our experience with several migrant tuberculosis cases necessitates some change or addition to be made to the inhospital care. Because of local rules as to residence requirements in order to be admitted to a tuberculosis hospital, and becuase of this no payment can be made to the T.B. hospital; it is practically impossible to get care for these occasionally very seriously ill and infectious patients. Migrant funds do not permit payment for hospitalization of a T.B. case in a non-tuberculosis hospital. Furthermore, the local hospital will not accept a T.B. case. A change is necessary here.

C. Other Health Care Facilities.

   1. Local physicians provide medical treatment for illness and injury on a fee-for-service basis. The same is done at the migrant family clinics. These provide immunizations, screening for hidden disease, family planning services, pre-and post-natal care, etc. Nurses assist physicians in the clinics, visit camps to advise patients to see project physicians and see that they understand and follow doctor's instructions. Diseases that need not happen must not happen. Diseases that can be detected and cured in early stages must not be allowed to run their course.

Chronic disease strikes rich and poor alike. But among the poor it kills or disables many who might be spared. Cervical cancer kills poor women because three decades after the pap smear test was developed, they still do not receive the benefits of this simple procedure. This need not happen. This can be an integral part of our health service system.

2. T.B. cases receive close follow-up by a T.B. consultant. Mental health patients are seen by our psychiatrist and followed with medication.

3. Incorporating family planning into the total maternal health program has increased attendance at post-partum clinics and made possible greater surveillance for cancer, syphilis, and other physical conditions developing after delivery. The evening clinics serve working mothers and those unable to attend during the day with family planning counseling and pills, etc.

   Many of the families served by this program have poor diets because of limited funds to purchase food, and lack of basic nutritional information. The nutritionist works in both the maternal and pediatric clinics counseling the professional personnel and explaining to mothers the basic rules of nutrition as well as diet modifications required by pregnancy and various physical conditions. Attempts are made through teaching and the distribution of pamphlets in simple language to improve the eating habits of the entire family. It has been observed that the main nutritional problems of low-income pregnant women are lack of protein, iron, and vitamin C.

4. Education has not received just attention as a poverty-fighting tool, because it is so obviously a slow process. Poverty must be fought through health education. Experience has shown that an effective way of altering family health practices is through education of the children. But the education of the migrant workers child is impeded by his migrancy and often his isolation far from schools, also by his working in the fields with his parents. Services of a professional health educator is absolutely essential.

   More emphasis should be placed on child health. The basic needs of the child are, indeed, protection against disease, adequate food, clean water, shelter and clothing, and an environment conducive to healthy emotional and social development. Does the health service reach the families most in need of the services? The sad health status of many children being examined should be traumatic enough to spur health workers to undertake a thorough reappraisal of their services!

D. **Relationships.**

The relationship of the project staff with the local growers has improved considerably, with time and effort. They do not hesitate to send farm workers to the clinics for care. They realize that early treatment prevents serious illness and as a result reduced absenteeism. The schedules of the clinics with addresses and telephone numbers of same are placed in growers' offices and places of employment. I, personally, have made the acquaintance of many growers through visiting with them and discussing our services. They were well pleased. Seven doctors from the local county medical society are involved in the care, treatment and follow-up of these migrant workers. They include a pediatrician, obstetrician/gynecologist, general surgeon, ear/eye/nose and throat specialist, general practitioner, urologist, and psychiatrist. Crew leaders have been helpful in referring injured and sick to the clinics, as they are aware of the care these workers have received and its benefits to them. Local migrant community groups assist their own in referring sick cases to us for home visitation, have implemented a day care center and are working on another; as well as transporting neighborhood sick to the clinic. Expansion of these relationships through more knowledge and education will involve other groups for further progress. The agricultural extension agents are very helpful to us concerning migrant habits, crop statistics and market demands, and the effect on employment.

E. Consultations.

State Welfare has assisted in referring family spacing patients for counseling and services. Consultation assistance from the pediatrician, psychiatrist and nutritionist was readily available and valuable, when needed.

F. Other Services Needed Are:

Services of a professional health educator with sufficient money in the budget to employ one either for a single county or for several counties. More education in all its phases is a must if we are to materially improve on present results. I am speaking of organized coordinated health education, not incidental and or leaflet and poster education. Project staff time permits very little efficient and sufficient health education.

G. Orientation.

Orientation or in-service training of personnel is advantageous especially for those not previously in public health work. However, training and instruction for those to work or working with migrants should include the culture, background, habits, likes and dislikes and attitudes, etc. of these people in order to better understand them and better their relationship. This is essential to achieve success in rendering services to them. Toward the close of the report year our project sanitarian received in-service training in Broward, Collier, and Lee counties.

III. General Appraisal of Year's Achievements.

A. The migrant project clinics have been highly successful in serving and improving the health status of these seasonal farm worker families. They, in turn, appreciate the courteous treatment by the physicians and nurses. At the present time, in Seminole County, we are participating in major efforts to improve the quality of medical care among these low-income families. More comprehensive and better continuity of care has been established. A second migrant clinic has recently been opened in a large, critically neglected farming area in South Seminole County. Hospitalization for delivery of maternity patients has been accomplished. Additional services have been expanded to all clinics. An I.U.D. clinic was started to increase family planning services. Expansion of services to day care centers in project clinic areas is being formulated. I feel that we have made progress in the past year. We have been able to do much more for the migrant because of funds and personnel received for this purpose.

B. Lack of organized concentrated health education is a problem we encounter often. The key is to remember that any program must emphasize the future, and to concentrate resources on long-range efforts. The best long-term bet, I think, is simply education. Experience suggests education is a better tool of social advancement than any alternative. Poor nutrition and other diseases are common to these low-income disadvantaged people living in housing conditions observers will agree sorely need upgrading. Poor diets are the natural result of low purchasing power, lack of adequate food, poor cooking, and storage facilities and lack of understanding of nutritional requirements. We cannot promise the poor wealth and success today, tomorrow, or even the next day; but we can begin to develop new and promising ways for involving the poor in the main stream of American life. We must provide services, assistance and other activities of sufficient scope and size to give promise of progress toward the elimination of poverty or causes of poverty through developing other employment opportunities, motivation and productivity. We have always known that heedless self-interest was bad morals; we know now that it is bad economics.

C. Strong points in achieving objectives were money; project staff; education; cooperation of local outside professional help; health care services rendered in clinics, at home, and in the hospital; improved housing and sanitation.

D. Our plans are:

1. To set up another migrant clinic in North Seminole County, a large farm and grove area in Monroe.
2. To further expand our services and increase the number of clinic sessions, if necessary.
3. To increase the project staff.
4. To provide more and better health education as mentioned several times before in this report.
5. To emphasize nutrition and continuity of care.
6. To put more emphasis on motivation and self-help.

IV. Future Plans.

Objectives we hope to obtain for 1968-69:

1. To bring as many services to these migrant families as possible in order to prevent illnesses with its complications which usually lead to chronic disease. This often causes repeated absenteeism with inability to work, more poverty, followed by indigency and a continued welfare dole. In order to render medical care to these people, services must be accessible to them, in other words, in the area in which they work. To travel ten miles for a physicians service and treatment after a long, hard day's work on the farm is out of the question; especially

since there is no means of travel. This involves the rest of the family also. Hence, it is imperative that serious considerations be given to the establishing of a clinic in the Monroe area which is criminally neglected. This area at the present time is unreached. With a little extra money, we can reach them, thus improving their health status.

2. Another important phase of our work which needs more time and professional attention is education. With more and better education we could expect cooperation in more instances than we do now because these migrants would be better prepared to accept our intentions. Organized educational approaches by an educator would expedite matters considerably. The project staff isn't sufficient nor time available to do much education, which is essential.

3. We will emphasize more nutrition in all its phases. Hold more classes and group talks, including individual counseling concerning diets, foods, cooking, refrigeration, etc., to improve the anemias so common and hopefully improve their health for self-help.

4. Since the majority of our migrant families live in Seminole County, that is, some part of the family, year-round, either through leasing, renting or owning their home, we are going to make a greater effort including volunteers from among them to involve them in community affairs, to interest them in environmental sanitation, local civic problems, in fact, become part of the main stream of life. We have already made a good start in this direction with interesting results.

5. The sanitation department is striving to install an inside toilet in every home in Midway and Oviedo where possible, hopefully by the close of 1969. This can be accomplished now that water service is available.

6. Involving migrant volunteers has helped to clean up many rodent and insect breeding areas through elimination of rubbish, stagnant pools, garbage, etc., which we are striving to continue and expand through 1969.

Though their lot has improved, America's migrant farm workers still travel a seemingly endless road of hardship. Most of them want steady work, a nice home, a car, clothes, education for the children, doctors when sickness comes, stability, comfort, friends. Most don't have any of these things. Instead, their lot is worry, strenuous work, overcrowded housing, and poor sanitation plus insufficient medical care and facilities. No wonder that their health is poor, and no wonder the tuberculosis rate is high among them.

The seasonal agricultural worker is at the bottom of the economic, educational, and community acceptance scale. "How will we eat?" Perhaps the migrants greatest worry is his lack of money. For the seasonal farm worker and his family there is constant anxiety - Will I have work tomorrow? And if I do not, how will we eat and purchase the bare essentials? Whether you have a doctor's degree or a fifth-grade education, it is still difficult for a family of seven to manage efficiently on $1,900 and less a year. "Traveling costs money." Another great problem for the seasonal agricultural worker is that of transportation. He must own a car. This is a drain on any budget. If the migrant worker cannot travel, his livelihood is gone.

What kinds of health problems do migrants talk about most often? Often mentioned as a serious problem was the difficulty of finding sanitary conditions in living quarters: bad housing. Ill health of children was the next in importance: diarrhea, sick babies, skin diseases (especially pyodermas and impetigo), worms and pregnancy which is often mentioned as a health problem. Overwork, fatigue, cuts, wrenched back, colds, etc.

The war on poverty is total war. Poverty and disease, ignorance and unemployment form a cycle that is self-perpetuating. Without adequate health care, the poor and their children will remain poor, apathetic and lacking the vitality to acquire an education and a decent job. As long as no one expects results tomorrow, it makes entirely good sense to do what we can today to improve the lot of the poor. Their progress helps the whole nation.

In the light of what I have written above and the experience gathered to date in serving these people, the only change I can see is to continue to improve present procedures as well as to include other plans of approach that will involve these people in self and community betterment.

NURSING

I. GENERAL DESCRIPTION OF NURSING SERVICE

During the year 1967-68, the migrants of Seminole County found friends, advice and medical help through the migrant clinic. We have helped others to recognize the migrants needs for understanding, respect and treatment as fellow human beings.

The migrant clinic staff consists of one sanitarian, three nurses, one clerk-typist, and four local physicians on a rotating basis. We have two daytime nursing clinics, two evening clinics weekly, a well-baby, glaucoma and pap smear clinic monthly at the Midway Migrant Project Clinic. At the Oviedo facility, there is one evening clinic per week, two daytime clinics, a special well-baby clinic monthly, and a pap and glaucoma screening clinic every other month.

The specific objectives of this program are to provide basic health services for the migrants, adapting these to the socio-cultural characteristics of this labor group, and to develop additional services for them as indicated. The Project is primarily to bring medical, dental, sanitation, and health education services to migrants.

We feel that these objectives have been met and that we have brought more medical, dental, and health education to the people by helping them to help themselves, seek medical attention early, return for follow-up care, and reporting to us when they leave our area, so that we can refer them and also help them to locate a clinic in their new area.

There has been considerable improvement in patient attendance and return visits to our medical clinics. We feel this is due largely to nurse-patient relationship and the encouragement of growers and other migrant families.

We are very fortunate to have private physicians who cooperate well when consultation is needed. Most of the referrals to private physicians are to specialists, who concur with the diagnosis of the clinic physician, give immediate treatment and instructions for the patients to return to the clinic.

II. SERVICES PROVIDED TO MIGRANTS

During day clinics, nurses are able to do preliminary work-up on prenatal patients, family planning patients, counseling and other necessary work. Immunizations are given during day and evening clinics at the convenience of the working parents. We have the services of a local pediatrician for our monthly infant and pre-school clinic. The mothers are given medical supervision in bringing up their children, nurse counseling and also nutritional advice. We find parents very eager for this service and many health problems have been found and referred for treatment to other physicians, Florida Crippled Children Commission and the Florida Council for the Blind.

We also have our own Glaucoma Clinic. It is held once a month and the response has been very good. We have found a few borderline cases and an eye specialist is treating them.

During visits to schools in preschool examinations and day care centers, it has been found that a program of care is greatly needed for routine surgical procedures, such as circumcisions and umbilical hernia repairs. Although we have In-Patient Hospitalization for acute cases, some of these conditions are being neglected.

Health education as part of our program is being provided during each clinic session by the use of flip charts, diagrams, literature, films and demonstrations. Our nutritionist counsels with patients, both individually and in groups.

One of our biggest problems has been, and still is, getting prenatals to seek care early in pregnancy. This situation is improving.

All medical services are offered at general medical clinics including referrals to prenatal clinics, dental referrals for emergency work, referrals for nutritional counseling and x-ray and laboratory referrals.

We are pleased to report that out-of-state referrals are more complete than last year, although it is still very difficult to locate some patients due to inadequate addresses and the names of employer or crew-leader being omitted. The problem of partnes' names on children referrals is also a continuing one.

III. GENERAL APPRAISAL OF NURSING PROGRAM

We feel that we have been inadequate in many ways, because the needs of the migrant family are so great; however, we have made much progress. We find more people are aware of the services available and are coming to us for help. This year, we have seen many new families in the clinics.

With hospital inpatient service added to our program, we have been able to help the acutely ill. The program has assisted us in helping sick adults and children, who otherwise would not have been helped, unless it was an emergency.

A problem which hindered the effectiveness of services, was the lack of transportation. With the opening of the Oviedo evening clinics, we will be able to reach the people who found it difficult or almost impossible to get to the Midway clinic because of the distance (20 miles one way).

1. Continue present clinic service

    a. General medical clinics twice weekly.

b. Infant and preschool, well-baby clinic each month, including special pap smear and glaucoma screening clinics.

c. Family planning clinics.

d. X-ray clinics.

e. Venereal disease clinic.

f. Pre-natal clinic.

g. Immunization clinics.

h. Supervision of the school child.

II. More visits to homes and closer supervision of families as well as follow-up care in our medical clinics.

III. T.B. testing program.

IV. Education

a. Working with other agencies and making the community aware of their responsibility to the migrant family.

b. Educating the migrant to community resources and helping them become a part of the community.

SANITATION

I. General Description of Sanitation Service.

Sanitation Staff: One project sanitarian (full-time); three health department sanitarians (part-time)

A sanitarian was employed in September, 1967, for full-time migrant work; therefore, we have been able to increase the sanitation services related to migrants considerably. A complete sanitation program has been set up to include education, surveys, cleanup campaigns and routine inspections of all sanitary facilities. Improvement has been made in all phases of environmental health. However, an expanded program is necessary in order to meet the objectives, especially expansion of health education.

The entire staff participates in the program in order to take advantage of knowledge the sanitarians who specialize in specific programs have to offer. Also, with participation by all staff members, we are in a better position to involve allied agencies in the migrant program. During routine contacts with community groups, lending agencies, County officials, etc. the sanitarians solicit support and assistance in dealing with the problems. This approach has developed good relationships and we find most agencies willing to render assistance when informed of the needs.

II. Migrants in Seminole County live in municipalities or the surrounding areas. The homes, boarding houses and rooms occupied range from good condition to barely habitable. Seminole County does not have a minimum housing code and enforcement of improvements to existing structures is carried out using the county building regulations and the State Sanitary Code. The City of Sanford has enforced a minimum housing code during the past year and twelve substandard houses have been demolished. The sanitation staff works with city personnel on surveys and in condemning substandard buildings. Seminole County has countywide regulations for all new construction and a building permit is required for each structure. Prior to final inspection and occupancy of a new building, the owner must furnish the building department with a certificate issued by the health department indicating the sanitary facilities have been approved. This procedure enables us to be assured of adequate facilities in all new buildings where migrants live, work, or visit.

Adequate water supplies for the migrant areas is continually stressed. Public water connections made in the Midway and Altamonte area continued during 1967. The City of Oviedo will have a municipal system in operation within thirty days and services will be available to all migrants in the metropolitan area. It does not appear public water service will be available in the Bookertown area (a section of Lake Monroe) for some time. Therefore, the program in this area is to secure deep wells with electric pumps and pressure tanks for water service at each residence and establishment.

We anticipate considerable increase in the installation of inside toilet facilities in the Oviedo area due to the availability of water service. With public water available, the total cost of installing plumbing is reduced making the improvements much easier to secure. Privies are not approved as a means of sewage disposal for any new building; therefore, with a continuous program of eliminating existing privies, we plan to completely eliminate privies within several years. The City of Altamonte Springs expects to have a city sewage system in operation within one year. A program is already underway to provide this service to the migrant areas. We have received cooperation from the city in planning for these areas.

Improvement in insect and rodent control has been accomplished by organizing cleanup campaigns. In cooperation with the Seminole County Action, Inc., cleanup campaigns involving the migrant families and volunteers, were conducted in two migrant areas. Commercial garbage collectors operating in Seminole County furnished trucks and drivers, at no charge, to haul rubbish and debris from these areas. This program was quite successful.

III. The work environment for migrants ranges from good to very poor. Surveys of all work areas have been made and our plans are to concentrate on the areas where adequate water and sewage facilities are not available for the workers. We have secured a number of improvements but there reamins much to be accomplished in this area. We are obtaining cooperation from growers, labor representatives and others in solving the sanitation problems at work locations.

IV. Health education is one of the most important phases of the program if we expect to secure permanent improvement in the environment and living habits of the migrants. The sanitation staff has an organized educational program which includes lectures, films, film strips and personal instructions in sanitation. We have learned that an educational program for a select group can stimulate interest in the community. These volunteers can be of considerable assistance in educating the masses. It has been interesting to note that people living in these areas, who have served in the Armed Forces, are usually more aware of sanitary hazards. These individuals were forced to maintain a certain living standard while in the service and thus make good volunteers to assist in educating their neighbors. There is much to be accomplished in education and a professional health educator would be very desirable. With the services of a health educator to coordinate a total program, much improvement could be made in a relatively short period of time.

V. - VI. Expansion of all sanitation services can now be accomplished with a full time sanitarian assigned to the program. Future plans include more frequent contacts with employers, officials and all interested organizations and groups. It is realized other agencies must be made aware that improvement of environmental health for the migrants is a community program and not confined to health department activities. Close relationship with banks, mortgage companies, etc. is anticipated. We find in many cases the sanitarian must make the first contact with an agency regarding an improvement loan. Once the preliminary contact is made, the owner or occupant responds more readily. The success of the cleanup campaigns indicates this should be conducted periodically and expanded to cover all migrant areas. In-service training programs are planned in order to learn improved precedures, methods and standards to use in securing the desired objectives.

The migrant sanitarian observed and studied the programs in Broward, Collier and Lee counties as this report year closed. This assignment was deemed most educational as it pertained to the same extremes of poor housing and sanitation problems that we are coping with.

HEALTH EDUCATION

I. General Description of Health Education Service

A. Health education is the most important phase of the health project. Much of health education should be directed toward keeping the well child well, the practice of preventive medicine, seeking early medical attention, and self-motivation. This is a large package which needs, as mentioned often in previous paragraphs, an organized professional program by health educators. Our health department staff has trained volunteers "aides" found among the migrants themselves to attempt to motivate their people to help themselves and their environment by becoming actively involved for their own betterment. This includes environmental sanitation, seeking early medical services, neighborhood organizing, interpretation of instructions, car pooling, etc.

B. The greatest need of the migrants is simple, practical health education as to personal health habits, preventive measures to combat infection, diet, sanitation, prenatal and child care. At the risk of stating the obvious, we want to observe that while the solution to poverty is money, if that money is in the form of perpetual charity it is no solution at all.

Well-being of the individual does not depend upon money alone, but upon accomplishment. Poverty breeds poverty in the same way success breeds success. Greater efforts must be made to reduce poverty through education and self-help. Plans providing for a permanent dole, guaranteed annual income are in themselves self-defeating for they perpetuate and encourage the very condition they seek to correct. The solution to poverty is productivity by the individual. To be productive, you must have employment, and to have employment you must have good health and training. Put another way, poverty can be solved by education. The more education, the more effective the solution.

C. Our relationship with migrants and growers is one of cooperation and helpfulness, and this is true of all persons involved. The growers speak to their farm workers on accident prevention, proper methods of procedure, needs for cleanliness and sanitation, as well as seeking early medical attention. The migrants are responding much better to health care because of the benefits and relief derived from medical treatment.

D. Outside assistance is obtained from consultations with a nutritionist, psychiatrist, medical advisory services, from the growers themselves through inspections and talks on proper methods and working procedures.

E. The most important consultation needed is in the field of health education, over and over.

II. We must stop juggling the symptoms of poverty and begin work at the basic causes. No man can perform at his peak or even near it if he and his family are plagued with not having the bare necessities of life. It is difficult, for example, to successfully undergo the learning process of special training if one is suffering from a toothache, ill health, hunger, or undernourishment, inadequate sleep and/or fatigue due to worrying about other family problems.

A. The above might well stem from improper diet, consumption of insanitary water, non-protective housing and insufficient household items, money for food being diverted for rent, due to insufficient family income, and a host of other problems. The above several paragraphs depict some of the problems worrying these people. Insufficient money, improper and not enough food, insanitary housing, illness, work, children. What to do? Many problems brought out through counseling concerned poor food habits, apparent apathy, fatigue, too many children, etc. Through group counseling many of these situations were discussed with good responses and results.

B. Venereal disease talks with use of visual aids, family planning lectures with films and model demonstrations, discussions of foods, calories, diets and film, and other talks presented to groups were very well accepted, stimulating some questions at the close. The main barrier was poor communication due to lack of sufficient repeated health education.

C. Problems discussed with growers: How to reduce absenteeism as a result of sickness and injury and the benefits to them. Their attitude toward the farm worker: Be more friendly and concerned with their lot. Better sanitation facilities, etc. The response to this by growers and employers was good and was evidently appreciated by the migrants, judging from overheard comments.

III. Appraisal of Effectiveness of Educational Effort.

Repeated educational efforts are successful but insufficient and not well organized due to lack of time. This could be much more satisfactory if a health educator could be obtained to do just that.

A. Multiple pregnancies have been reduced by the use of the pill. The recent use of the intrauterine device will help further. Prenatal overweight has been brought under control by group talks on diet and food preparation by the nutritionist. Prenatals working late on the farms can now visit at the evening clinics for follow-up care. Many iron deficiency anemias are being treated with iron medication with steady improvement in the hemoglobin reading. All migrant babies are seen regularly by the pediatrician in the baby clinic, from one month post-natal until they are one year old. The response has been very good. The problem of seeking medical treatment early is slowly but surely taking hold as shown by the increase in numbers in the night clinics.

B. More and better coordinated organized professional health education is necessary; this by a health educator. There should be hospitalization of persons with tuberculosis that do not meet local residence requirements and are residents of nowhere.

IV. Specific Plans for Future Objectives, Procedures, Relationships, etc.

Our objective is to reach more of these migrants. Another clinic in the Monroe area, in north Seminole County, a distance of at least fifteen miles from the nearest health facility available at the present time. This is an area of large vegetable growing farms and groves housing approximately 3,000 migrants for a period of about eight months. There is much to be done here since transportation is practically non-existent, and few seek medical attention. Lack of personnel impedes us from rendering much service to them.

A closer relationship between growers, farm workers and professional medical personnel will increase our results to these people, especially if we can continue the approach used at present. We are looking forward to offering more and better services by more experienced professional personnel.

In Ecclesiasticus the patient is advised . . . "pray unto the Lord . . . then give place to the physician, for the Lord hath created him; let him not go from thee, for thou has need of him."

FUTURE PLANS

In the months remaining in this project year, we expect to continue project activities and expand on them where possible.

During the last half of 1967, approximately sixty (60) slides were added to our slide library, bringing the total to 240. The slide series is used in publicizing the various project activities and services before audiences unfamiliar with migrants and/or the Migrant Health Project. The slides have proven to be an extremely effective vehicle for getting our story across to the public. It is planned to replace some of the outmoded slides with new ones to be obtained this year. In addition, a slide series - to be used by the Nutrition Consultant in working with migrants - will be developed this summer. It is also planned to print some educational leaflets on nutrition to be distributed to migrants. Naturally, the food demonstrations presently being carried on by the project nutritionist will be continued through the remainder of the year.

Difficulty has been experienced, during the past year, in filling project sanitarian positions in some counties. The picture has been brightened in this regard recently. Although a steady improvement was noted in migrant housing during the report year, this advance could not be labeled as rapid.

We anticipate a tightening of enforcement of the Florida State Sanitary Code as it relates to housing during the months remaining in 1968, and a continuation of this policy during 1969.

The Health Service Indexes for the eleven (11) states participating in the system will be revised and condensed into one volume this summer. The proposed new Referral Form, which is an improvement over the one presently in use, (a reprinting of the latter was recently made) will, hopefully, be printed and distributed before the return of the migrants this fall.

An East Coast Migrant Health Conference was held in Orlando during the latter part of March, 1968. Thirteen (13) states and Puerto Rico were represented at this conference, the attendance numbering approximately 200 persons. Continuity of health care came in for some attention during the conference, and as a result, interest in the use of the Health Service Index/Referral Form System and the Personal Health Record (PHS-3652/1-61) has heightened. We recently distributed 9,100 Personal Health Records amount the seventeen (17) Migrant Health Project counties in Florida and expect them to be used more than they have been previously. We plan to encourage project nursing personnel to issue these records to all migrants with whom they come in contact.

The third annual Florida Migrant Health Conference was held at Miami Beach during the middle of November, 1967. The conference was attended by approximately 175 public health workers, some of them being from states outside Florida...Among the program topics presented were:

"Puerto Rico's Migrant Project"
"The Grower and the Migrant"
"Planned Parenthood"
"Field Sanitation"
"Legal Aid to Migrants"
"Self-Help Housing"
"Annual Report - The New Forms"

It is planned to hold another annual conference, financed by project funds, this fall. These conferences are part of our in-service training program and are held for the purpose of educating new personnel in, and keeping the long term personnel abreast of, latest developments in the field of migrant health. The in-service training program also includes visits by project personnel to other project counties to observe their programs and modus operandi. This phase of the training program will continue this year as before.

PROJECT GRANT NUMBER: MG-18E (68)

PROJECT TITLE: A Project to Develop a Statewide Program of Health Services for Migrant Farm Workers and their Dependents in Florida.

PERIOD COVERED: May 1, 1967 through April 30, 1968

SUMMARY

The fifth year or grant period of the Florida Migrant Health Project began in January, 1968, with fifteen (15) county health departments participating and ends on the last day of this year. The period covered in this present Annual Progress Report extends from May 1, 1967, through April 30, 1968. During this report period there was, with few exceptions, a definite increase in the amount and variety of services rendered, the number of agricultural migrants brought into contact with these services, and the various activities carried on by migrant project personnel in Florida.

During the 1967-68 agricultural season, migrant workers began arriving during the latter part of August, 1967. Employment reached peak level on January 31, 1968, with an estimated 78,037 workers. At this time there were approximately 30,700 workers in citrus harvest and grove care, and 9,600 in sugarcane. About 8,400 of the sugarcane workers were from the British West Indies. The ethnic composition of the domestic work force was estimated to be: Anglo, 17 per cent; Texas-Mexican, 15 per cent; Negro, 58 per cent; Puerto Rican, 10 per cent. Generally, during the 1967-68 growing season, the labor supply and demand were in good balance. The drought which occurred in the spring was unfortunate in many of its effects.

Mechanization continued to increase during the 1967-68 season. In South Florida, the harvest of potatoes, radishes and Southern peas was accomplished almost entirely by machinery. More growers began using the mechanical harvesters for celery, sweet corn, tung nuts and tobacco. Little labor was displaced, since more jobs were created by the use of machinery. Labor requirements for the 1968-69 growing season are not expected to vary substantially from those of the 1967-68 season. Migrant workers begin leaving Florida during May with heavy migration during June, after school terms have been completed. Around 40,000 to 45,000 workers and their families are expected to leave Florida this year.

There were 1,402 Migrant Health Service Referrals made during this reporting period, an increase of 180 over the previous same period. These referrals include both inter and intrastate and were made on the form that Florida devised for this purpose of assuring continuity of care. Because difficulties were experienced in arranging for the printing of an improved form, reprinting and distribution of a supply of the existing form was necessary. The existing Health Service Referral Indexes for the eleven (11) participating states will be updated and incorporated into one volume before the end of this year. It is hoped that the proposed new referral form will also be printed by then.

Project objectives were substantially achieved during the present report period with one exception; i.e., to increase the number of counties participating in the project. One county (Alachua) withdrew during this report period. Some counties instituted planned parenthood clinics for migrants, in Seminole County a migrant clinic was installed in the town of Oviedo, and in Lee County a weekly migrant dental clinic was initiated. Medical and dental clinics began operation in St. Lucie and Martin Counties.

Difficulty was experienced in filling some sanitarian positions in a few counties due to lack of qualified personnel in this discipline and the rather modest financial remuneration offered for the position. There was some improvement in migrant housing, but not enough of it to satisfy some news media.

Health education activities increased, slanted both toward the migrants and the general public. Approximately sixty (60) new slides were developed which portray project activities and more will be added to the slide library before December. A public health educator was employed in mid-summer of 1967.

In September, 1967, a team of four public health advisors and a coordinator were assigned to a special project titled: "Migrant Syphilis Casefinding Demonstration Project." This was financed by U. S. Public Health Service Funds. So far, 14,033 blood tests have been obtained, 221 cases of infectious and 105 cases of early latent syphilis have been identified and five objectives of this particular project have been pursued.

In February, 1968, a nutrition coordinator for the Migrant Health Project was employed. As a result, nutrition services have been expanded to meet the needs and problems of migrants in additional areas of the state.

A migrant health conference for in-service training of project personnel was held at Miami Beach during November, 1967. Approximately 175 persons attended the 2½ day meeting, several of them from states outside Florida. It is planned to hold another such conference in the fall of 1968. During the latter part of March of this year, an East Coast Migrant Health Conference was held at Orlando. Approximately 200 persons attended this meeting which was funded by the U. S. Public Health Service. Public health personnel from 13 states, Puerto Rico, and the U. S. Public Health Service were in attendance.